PRIVATE LONG-TERM CARE INSURANCE AND STANDARDS TO PROVIDE FOR IMPROVED CONSUMER PROTECTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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PRIVATE LONG-TERM CARE INSURANCE AND STANDARDS TO PROVIDE FOR IMPROVED CONSUMER PROTECTION

THURSDAY, APRIL 11, 1991

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:37 a.m., in room B-318, Rayburn House Office Building, Hon. Fortney Pete Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
THURSDAY, MARCH 28, 1991

PRESS RELEASE #6
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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THE HONORABLE PETE STARK (D.,CALIF.), CHAIRMAN,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES,
ANNOUNCES A HEARING ON
PRIVATE LONG-TERM CARE INSURANCE AND STANDARDS TO PROVIDE FOR IMPROVED CONSUMER PROTECTION

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a hearing on private long-term care insurance and standards for improved consumer protection.

The hearing will examine the status of private long-term care insurance policies and will consider proposals to establish Federal consumer protection standards. The hearing will be held on Thursday, April 11, 1991, beginning at 9:30 a.m., in room B-318 of Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "The absence of a public long-term care program has created a small, but growing market for private long-term care insurance. Unfortunately, a substantial portion of policies sold may be of minimal value to policy-holders. Last year, Congress enacted Federal standards to protect consumers of Medigap policies. This hearing will examine the necessity of Federal standards for long-term care insurance policies."

Oral testimony will be heard from **invited witnesses only**. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The private long-term care insurance market is a relatively new, but rapidly growing market. According to the Health Insurance Association of America, the number of polices sold in the last two and one half years has doubled from 815,000 to more than 1.65 million policies by June 1990. More than 130 companies sold long-term care insurance as of mid-1990.

In recent years, three serious concerns have been identified in the long-term care insurance market. First, private insurance is unlikely to be the primary source of long-term care financing because policies are too expensive for the majority of elderly persons.

Second, policies are being sold to elderly consumers with numerous shortcomings, including but not limited to: the absence of adequate inflation protection; high lapse rates and the absence of nonforfeiture benefits; questionable pricing practices; post-claims underwriting; ambiguous eligibility triggers for covered benefits, and prior hospitalization requirements.

A third problem is the limited oversight and regulation of such policies by State regulatory agencies.

(MORE)

In response to the testimony presented at the hearing, the U.S. General Accounting Office (GAO) was asked to conduct a study to review private long-term care insurance policies and State regulatory practices with respect to such policies. The GAO was also asked to include in its report recommendations for minimum standards for long-term care insurance. The GAO will present its findings at the April 11th hearing.

In contrast to Medicare Supplemental Insurance (Medigap) policies, there are no Federal standards for private long-term care insurance policies under current law.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Thursday, April 25, 1991, to Robert J. Leonard, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will **not** be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.
2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.
3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.
4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and public during the course of a public hearing, may be submitted in other forms.

Chairman STARK. This morning the subcommittee will begin work in the area of long-term care insurance, the cost of which poses a serious financial threat and has been viewed by many of us on the subcommittee as a financial issue more than a medical issue.

Today's hearing will focus on private long-term care insurance policies. The absence of a public long-term care program has created a void for many seniors and their families. And some attempt is being made to fill this void with a small but growing market for private long-term care insurance.

Unfortunately as we will hear this morning a substantial portion of the privately sold long-term care policies are of minimal value to current policyholders and could commonly be referred to as a rip off.

The decision to purchase private long-term care insurance is a risky enterprise for the average consumer. It is about like buying a used car.

Even the most well informed insurance customer would have great difficulty deciphering the hidden loopholes, the vagaries and limitations of many of the long-term care products in the market today. We point out that private long-term care insurance will never be a solution for a majority of America's seniors. Few can afford a relatively good policy which, according to the Health Insurance Association of America, is priced at about $1,400 a year for an average 65 year old.

Still fewer can afford the premiums of a more generous or higher quality policy. Keep in mind that those who buy long-term care insurance at $1,400 a year may have other substantial out-of-pocket medical costs. The majority of seniors buy medigap policies, particularly those who can afford long-term care, and they pay well over $700 a year for those policies.

Seniors are also likely to have other medical bills that are not covered by Medicare, medigap, or private long-term care insurance, such as prescription drugs, which are among the most expensive. At best, the private long-term care insurance market holds some promise for protecting the income and assets of the relatively well off older Americans. However, it will never be a comprehensive solution to address this Nation's long-term care needs.

This morning we will hear about the failure of States to adopt critical consumer protection measures, illustrated by the recent bailout of Executive Life of California and the failure of the State Insurance Commissioner to close them. It should be noted that the failure precedes the late, great and famous John Garrimendi who just ran for election in that job. I must point out it was the previous insurance commissioner who failed to close them.

We will also hear about numerous problems that plague seniors who purchase long-term care insurance. These problems include but are not limited to inadequate and in some cases nonexistent inflation protection, and the absence of benefits on lapsed policies. Read that to say that as the policies are canceled and have built up huge values or internal reserves, they are not accorded the same treatment that life insurance policies would be treated because in this case the company pockets the cash value. It does not return it to the policyholder.

Bait and switch pricing practices lure in customers before imposing hefty price or premium increases. Overly restrictive and indeed ambiguous eligibility standards which come back and haunt a claimant when he or she tries to file a claim. Refer to that as post-claims underwriting. On the street it is called welching on a promise.

Last year the Congress enacted meaningful Federal consumer protection standards for medigap policies. Under current law, there are no Federal standards for private long-term care insurance. Today we will consider the necessity of enacting Federal standards to provide meaningful protection for consumers of private long-term care insurance.

I look forward to the testimony and would be happy to yield to my colleague from New York.

Mr. MCGRATH. Thank you, Mr. Chairman, and I thank you for holding these hearings on private long-term care insurance. Many senior citizens in New York inform me that they cannot afford to purchase long-term care policies because the premiums have increased by as much as 50 percent each year.

Too many seniors must make the decision to pay the huge premium increases or let their policies lapse. Because the financial burden of paying out of pocket expenses for nursing home expenses can wipe out a senior citizen's savings account, many go ahead and pay the higher premiums for long-term care protection, perhaps even to the denial of other needs.

It is very confusing for a senior citizen to decide which policy would provide the best long-term care benefits. Unfortunately, information on many policies sold today is vague, leaving consumers uncertain when making this very important purchase.

For the majority of middle class older Americans, purchasing long-term care policies can be financially threatening. In addition to paying the premiums for a long-term care policy, they must pay for medigap policies and prescription drugs which can easily add up to hundreds of dollars each month. For seniors who are on a fixed income, this can become devastating.

New York's Insurance Commission provides adequate consumer protection measures for their policyholders. I, however, believe that New York and the rest of the Nation can make improvements in their long-term care policies in the areas of inflation protection and overly restrictive and ambiguous eligibility standards.

Today we will be hearing testimony from our witnesses which will provide us with information related to what is currently happening in the private long-term care insurance market. I look forward to these hearings and what our witnesses have to say.

Thank you, Mr. Chairman.

Chairman STARK. Thank you. Do any other members care to make a statement?

[No response.]

Chairman STARK. Our first witness this morning is Ms. Janet Shikles, the Director of Health Financing and Policy Issues for the U.S. General Accounting Office. Ms. Shikles will present the GAOs findings on a report initiated at the request of the Chair on the status of private long-term care insurance.

Welcome to the committee, Janet. Would you like to introduce your colleagues and proceed to enlighten us in any manner that you are comfortable?

STATEMENT OF JANET L. SHIKLES, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY EDWARD STROPKO AND JOEL HAMILTON

Ms. SHIKLES. Thank you. I would first like to introduce Ed Stropko and Joel Hamilton, who led the work for this subcommittee.

Mr. Chairman and members of the committee, I am pleased to be here today to discuss the preliminary results of our review of long-term care insurance policies and the standards that govern them. We found in our review that although States have progressed in recent years, most still lag in adopting NAIC standards, even those developed between 1986 and 1988.

For example, 24 States still have not developed policies requiring insurers to guarantee policy renewal; 18 have not adopted standards disallowing Alzheimer's exclusions. Even fewer States meet the standards NAIC established after 1988. Insurers have adopted these standards more quickly than States have, but most policies we reviewed still do not comply with all NAIC standards.

For example, 10 of the 44 policies that we reviewed drawn from eight States and currently being sold in these States offer no inflation protection. Of those that do offer inflation protection only one meets the NAIC standard. We also found that even when long-term care policies meet the NAIC standards, consumers still face many difficulties in assessing policy benefits.

Neither States nor NAIC have developed uniform definitions of long-term care benefits, and thus it is difficult for consumers to compare policies. In addition, most policies contain definitions that potentially limit access to benefits. Of the 44 policies that we reviewed, 23 define levels of care restrictively; 37 define facilities restrictively. And I will give you a couple of examples.

First, one individual learned that the insurer would not provide benefits unless he received care in a nursing home that maintained a daily medical record for each resident. He discovered that his State did not require such records and that he would have difficulty locating a nursing home in his area that did.

Second, a woman who had been a policyholder complained to her State insurance commissioner that her insurer would not provide benefits unless she received care in a nursing home with 24-hour nursing services provided by a registered nurse. She spoke with several nursing homes in her area and found that none met these requirements.

In addition, policyholders face problems concerning how eligibility for benefits is determined. In our sample of 44 policies we found many that used criteria that either were not defined or were defined in ways that could be very restrictive. Thus the insurer's contractual obligations to provide benefits were not always clear, and when they were oftentimes they were, very limited.

For example, most of the policies that we reviewed said that they would cover Alzheimer's disease or policyholders who had Alzheimer's. However, when you looked at the policies carefully and how the benefit eligibility would be determined, many policyholders with Alzheimer's would not be covered. Consumers face another risk in purchasing long-term care insurance, paying an inappropriate price.

We found substantial differences in premiums for similar policies and little consensus among the actuaries we consulted on the definition of a reasonable price. We found that annual premiums for policies that would appear similar to consumers can vary by over 100 percent. For example, annual premiums for six policies that covered both nursing home and home health benefits ranged from about $1,200 to $3,000.

Furthermore, even policyholders who obtain long-term care insurance at the lowest price cannot be sure they have obtained a bargain. Under NAIC standards, insurers can increase premiums on existing policies. We identified 12 requests for price increases in three States where we were able to obtain this kind of information.

Arizona had 11 of the 12 requests for price increases ranging from 15 to 54 percent. Between 1988 and 1990 the State allowed increases for all 11 policies. We think it is surprising to see so many approvals for rate increases since these products have not been on the market that long and one would not expect that insurers would have enough claims experience yet to justify these rate increases.

Premium increases are an obvious concern because policyholders can be priced out of the market at a time when they are most in need of coverage. Compounding this problem, policyholders can lose all of their investment in premiums if they allow their policies to lapse. In fact, insurers expect that this will be the situation for many individuals.

On average, the insurers we reviewed at the State level expected, and told the States that they expected, 60 percent or more of their original policyholders to allow their policies to lapse within 10 years. One insurer told the State they expected an 89 percent lapse rate.

In all but 2 of the 44 policies we reviewed individuals would forfeit their entire investment in premiums if they allowed their policies to lapse. Based on our review of policies, a consumer who purchases a policy at the age of 75 and allows it to lapse at the age of 85 will, on average, lose about $20,000 in premium payments.

Finally, most insurers pay high first year sales commissions for their long-term care policies. Such commissions encouraged marketing abuses in the sale of medigap policies and pose a similar problem for long-term care insurance. Medigap standards have been revised to reduce these incentives by limiting the size of the first year commissions paid to a sales agent

NAIC has adopted the same commission standards for long-term care insurance, but it has established them as an option. We saw little evidence that insurers will elect to follow these standards. Nearly all were paying agents substantially higher commissions than are allowed by the NAIC standards. With one such policy we reviewed, a sales agent could earn an initial commission of $2,000 for selling the policy to a 75-year-old.

In conclusion, although long-term care insurance standards and policies have improved, we believe that consumers still face considerable risks in purchasing these policies. In addition, while States have progressed in recent years, many do not conform to the standards suggested by NAIC and future State action is unclear.

The Congress, therefore, may wish to consider enacting Federal legislation to establish minimum standards for long-term care insurance. We also believe that the Congress should consider strengthening these standards in particular areas, such as developing more uniform definitions for services and eligibility criteria, requiring nonforfeiture benefits, establishing minimum standards that allow consumers to upgrade policies, establishing a grievance procedure—now if you disagree with your insurer about your eligibility benefits, you probably have to go to court—and requiring the same standards for agent commissions in long-term care insurance as required in medigap.

Mr. Chairman, this concludes my statement and my colleagues and I would be very pleased to answer any questions.

[The prepared statement follows:]

TESTIMONY OF JANET L. SHIKLES, DIRECTOR
HEALTH FINANCING AND POLICY ISSUES, HUMAN RESOURCES DIVISION
UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the preliminary results of our review of long-term care insurance policies and the standards that govern them. Hearings before your Subcommittee in 1989 identified significant problems involving the adequacy of both the policies and standards for them. Although expensive, many policies were found to be restrictive. States were slow to adopt model regulatory standards, and the model standards offered little consumer protection in key areas such as inflation protection. In light of these problems, you asked us for a status report on the policies and the current standards. You also asked us to report on whether there is a need for minimum federal standards.

BACKGROUND

Long-term care refers to a range of medical and support services provided to people who have lost their capacity to function independently because of a chronic illness or condition. Recent estimates predict that 43 percent of Americans who turned 65-years-old last year will enter a nursing home at some point in their lives, and 24 percent will stay 1 year or more.[1] For most people, long-term care presents an unbearable financial strain. For example, nursing home care can cost $30,000 or more a year. In response to consumers' desire to be protected from these costs, the private long-term care insurance market has expanded greatly. Before 1986, few companies offered long-term care insurance. By June 1990, 1.6 million policies had been sold by 130 or more companies.[2]

Private long-term care insurance policies typically offer indemnity benefits for nursing care.[3] That is, these policies pay a set amount each day for a specific period of time a policyholder receives care. A policy may or may not cover all types of long-term care, and different policies may define covered long-term care services or facilities differently. In addition, many policies also cover home care services.

Traditionally, states have had the primary responsibility for regulating the insurance industry. State insurance regulatory agencies are linked through the National Association of Insurance Commissioners (NAIC), which comprises the heads of the state agencies. As with other types of insurance, NAIC establishes standards for regulating long-term care insurance, but these standards are not mandatory. State regulatory agencies have the ultimate responsibility for setting the state standards.

The market for long-term care insurance resembles the market for Medicare supplemental or "Medigap" insurance in the 1970s. Early Medigap policies varied greatly in value and coverage. State regulation was inconsistent, with sales and marketing abuses a recurring problem. Similar problems were identified with long-term care insurance in hearings before this Subcommittee in 1989. In light of these problems, the Subcommittee asked that we assess (1) the extent to which state standards and long-term care insurance policies meet NAIC standards; (2) the adequacy with which the standards and policies address consumer protection issues such as the definition of benefits, determination of eligibility, and inflation protection; and (3) whether there is a need for minimum federal standards.

SCOPE AND METHODOLOGY

We compared each state's long-term care laws and regulations with NAIC standards to identify the strengths and weaknesses of state regulatory standards. The NAIC provided us with the states' current laws and regulations.[5] To determine whether insurance policies meet NAIC standards, we reviewed 44 policies for sale by 27 insurers in eight states (Alabama, Arizona, California, Florida, Missouri, New Jersey, Pennsylvania, and Washington). To obtain policies for review, we randomly selected

insurers in each state from the universe of insurers with policies approved for sale. Then, we assessed whether the policies these insurers were currently selling meet key NAIC and state standards.

We also consulted officials of insurance organizations such as the NAIC, as well as major consumer groups and private and government actuaries. We considered their views in our assessment of the adequacy of standards in addressing consumer protection issues.

STATE STANDARDS AND INSURANCE POLICY PROVISIONS OFTEN DO NOT MEET NAIC STANDARDS

Over the past 5 years NAIC standards have improved significantly. The standards are not mandatory, however, and the states have continued to lag behind in adopting them. Insurers have been more responsive to NAIC standards than the states, but policies still do not meet several key standards.

NAIC Standards Strengthened

Since 1986, NAIC has amended its standards annually. Early standards aimed at eliminating many restrictive policy provisions, such as excluding coverage for people with Alzheimer's disease or denying policyholders the right to renew their policies.[6] NAIC amendments sought to clarify policies by establishing standards requiring an outline of coverage that describes policy benefits, exclusions, and renewal provisions.

More recent amendments recommend that states prohibit insurers from requiring that policyholders be hospitalized before they can enter nursing homes; these amendments also protect policyholders against post-claims underwriting. This practice involves denying claims based on technical details, such as omission of information not explicitly requested or provided on the policy application form. NAIC has also sought to improve policies by strengthening inflation protection standards and establishing minimum standards for home health care benefits.

States Lag in Adopting NAIC Standards

Although states have progressed since we last reported on the issue, most states still lag in adopting key NAIC standards.[7] The differences between NAIC and state standards may result, in part, from the time required to develop new legislation or regulations. However, many states still do not meet NAIC standards developed between 1986 and 1988. For example, 24 states still have not developed standards requiring insurers to guarantee policy renewal. In addition, 19 states have not developed standards, or met those developed, prohibiting the prior hospitalization requirement. And 18 states have not adopted standards prohibiting exclusions for Alzheimer's disease. Even fewer states meet the standards NAIC established after 1988. For example, 40 states have not adopted NAIC standards for home health care benefits, inflation protection, or disclosure requirements for post-claims underwriting.

Policies Improved but Do Not Meet Recent NAIC Standards

Insurers have adopted NAIC standards more quickly than states. For example, most of the 44 policies we reviewed meet the key NAIC standards developed in 1988 or earlier. The policies often do not meet more recent NAIC standards, however, especially the disclosure standards.

Disclosure standards help protect consumers from unfair or deceptive marketing practices. For instance, to determine whether insurance agents are selling unnecessary insurance or

unfairly targeting individuals, NAIC standards require specific information on policy applications. But none of the applications we reviewed meet all NAIC standards. For example, 20 do not ask whether the applicants are already covered by Medicaid, and 42 do not ask whether the applicants had other long-term care insurance in the past 12 months and who sold it to them.

Insurers should adopt these standards because the standards include important information insurers need to determine whether an applicant should purchase long-term care insurance. Some insurers have had problems with aggressive sales agents selling policies to consumers who do not need them. We found several cases of these problems. In one case, the state of California brought suit against an insurance agency whose agents sold unnecessary policies to 100 or more older consumers. The agents sold an older man 16 different health policies over 3-1/2 years; about half of the policies provided nursing home coverage. These problems might have been avoided if the insurer had met NAIC disclosure requirements and used the information to monitor its agents.

Some policies we reviewed also do not meet NAIC standards for determining eligibility for home health care. These standards were designed to eliminate overly restrictive provisions. However, of the 37 policies that offer home health care, 10 policies contain such restrictive provisions. That is, 5 still require policyholders to receive nursing home care before home health care benefits are provided, and 5 require a physician to certify that without home health care, the policyholder would need to be in a hospital or nursing home. Neither of these provisions is permissible under NAIC standards because each is considered too restrictive.

Lastly, 10 policies offer no inflation protection. We found only 1 policy containing an inflation protection provision that meets current NAIC standards. This policy meets the standard that requires benefits to be increased at the rate of 5 percent or more, compounded annually.

In contrast, most other policies that offer inflation protection use a simple rate of inflation that increases benefits by 5 percent or less annually. Many of these policies also limit the inflation increases either to a certain period of time (generally 10 to 20 years), a percentage of the daily benefit (generally benefits can be increased by 50 to 75 percent), or until the time a policyholder reaches a certain age. The age limits are most restrictive for elderly policyholders. For example, two policies stop making inflation adjustments when a policyholder reaches the age of 70. As the average policyholder is near this age when he or she purchases long-term care insurance, these policies eliminate inflation protection for many policyholders.

NAIC STANDARDS DO NOT ADDRESS DEFINITIONS, ELIGIBILITY CRITERIA, AND GRIEVANCES

Consumers face many difficulties in assessing long-term care policies, even when policies meet current NAIC standards. Some of these difficulties arise because policies vary so widely in how they (1) define covered benefits and (2) determine eligibility for benefits. In addition, determining a policyholder's eligibility for benefits involves considerable judgement, and a policyholder and insurer can disagree about whether benefits should be provided. A grievance process could help resolve such disputes.

Definitions for Levels of Care and Facilities Often Restrictive

Neither states nor NAIC has developed uniform definitions of long-term care benefits. As a result, definitions for levels of care and facilities differ widely in the policies we reviewed. These differences make it difficult for consumers to compare policies.

In addition, most policies contain definitions that potentially limit access to benefits. Of the 44 policies we reviewed, 23 define levels of care restrictively, and 37 define facilities restrictively. Such definitions can have the effect of eliminating coverage for benefits typically offered to nursing home residents or reducing the number of nursing homes available to policyholders who would otherwise qualify for benefits. For instance,

-- 10 policies limit benefits through their definition of skilled or intermediate care (for example, 1 policy excludes physical therapy from the definition of skilled care, though the service is typically included in skilled care);

-- 22 require that facilities keep daily medical records, which is not required by Medicare or the states we visited;

-- 12 require that facilities provide 24-hour nursing service for custodial care (several states we visited do not have this requirement); and

-- 12 require that custodial care be provided in a skilled or intermediate care facility.

Two complaints to state commissioners illustrate the problems that policyholders face with definitions of facilities. First, a man who was a policyholder learned that the insurer would not provide benefits unless he received care in a nursing home that maintained a daily medical record for each resident; he discovered that his state did not require such records and that he would have difficulty locating a nursing home in his area that did. Second, a woman who had been a policyholder complained that her insurer would not provide benefits unless she received care in a nursing home with 24-hour nursing services; the policy also required that the nursing services be provided by a registered nurse. She spoke with several nursing homes in her area and found that none met these requirements.

No Criteria for Determining Eligibility

Policyholders face additional problems about how their eligibility for benefits is determined. To avoid confusion, policies should clearly explain eligibility criteria. These "gatekeeper" criteria may be the most important provisions in a long-term care insurance policy because these criteria determine how and when a policyholder will receive benefits.

NAIC recommends that states prohibit insurers from using certain restrictive eligibility criteria such as prior hospitalization. NAIC standards discourage insurers from using these criteria, but NAIC has not provided alternative eligibility criteria. In our sample of 44 policies, we found many that used criteria that were either not defined or were defined in ways that could potentially be restrictive. Thus, the insurer's contractual obligations to provide benefits were not always clear.

Many insurers replaced prior hospitalization criteria with criteria that requires "medically necessary" care. But some

policies do not define the term. Of the 30 policies that use medical necessity as a criterion for determining eligibility, 6 leave the term undefined. Apart from problems with the definition, use of medical necessity for determining eligibility can be quite restrictive. For example, some policyholders who require custodial or home health care may not need medical services. However, they may need services because they are physically or cognitively impaired. For these less intensive levels of care, other criteria for determining impairment might better assure that policyholders receive necessary benefits.

Our review of policies indicates that many insurers are beginning to use other measures of impairment. For example, 27 policies use limits in activities of daily living (ADLs) to determine when benefits would be provided. These activities include bathing, transferring from a bed or a chair, dressing, toileting, and eating. Although ADLs are promising criteria for determining eligibility for benefits, some policies that we reviewed have significant problems with ADLs. Of the 27 policies that use ADLs, 17 do not specify or describe the ADLs that the insurer would use to determine whether benefits would be paid. Such descriptions are critical because they determine the number of policyholders who will receive benefits.

Another issue involves how insurers determine whether policyholders are impaired in their ADLs and thus eligible for benefits. Some policies consider policyholders to be impaired if they can only perform the ADLs with active human assistance; others require that policyholders need "supervision or stand-by" help or mechanical assistance. Requiring that policyholders need active human assistance can reduce the number of elderly qualifying for benefits by 40 percent.[8] Of the 27 policies that use ADLs, only 1 requires supervision or stand-by assistance. The remaining 26 policies make it difficult to determine how the insurer evaluates impairment--17 require human assistance, but do not specify whether it has to be active assistance; and 9 do not describe the type of assistance required.

ADLs alone are often inadequate criteria for determining benefit eligibility. For example, nearly all policies specifically claim to cover policyholders with Alzheimer's disease. A substantial proportion of people with Alzheimer's disease, however, do not have serious ADL limitations. These people--who suffer from cognitive impairment and need supervision--often require different eligibility criteria. Of 27 policies that use ADLs, only 8 include cognitive impairment as an eligibility criterion. Absent any measure of cognitive impairment, policyholders with Alzheimer's disease must meet ADL requirements.

Finally, some policies present special problems when they combine medical necessity with ADLs or measures of cognitive impairment. For example, of the 27 policies, 5 require that a policyholder meet both medical necessity and ADL criteria to obtain benefits. In this situation, a policyholder could need assistance with an ADL but not receive benefits because he or she could not meet the insurer's requirements for the medical necessity criteria. Other policies do not have this problem because they allow medical necessity or other criteria such as ADLs or cognitive impairment.

Standards Do Not Address Consumer Grievance Process

Determining the need for long-term care services is a matter of considerable judgement. Whatever standards insurers use to make determinations--medical necessity or ADL criteria--different people can reach different conclusions about a policyholder's eligibility. Given this situation, a grievance process could help to resolve differences of opinion over whether benefits

should be provided. Ten policies we reviewed offer some type of grievance process although they vary in detail and formality. Of these, most simply indicate that the insurer will reconsider the policyholder's claim and review any material the policyholder submitted in support of it.

NAIC STANDARDS DO NOT PROTECT CONSUMERS FROM INAPPROPRIATE PRICES

NAIC standards give insurers considerable discretion in establishing premiums for new policies and in changing premiums for policies that are already on the market. As a result, consumers face another risk in purchasing long-term care insurance: paying an inappropriate price.

Premiums Can Vary Widely for Similar Policies

We found substantial differences in premiums for similar polices and little consensus among actuaries on the definition of a reasonable price. As a result, price is not always a good measure of value. For example, annual premiums for six policies that offer nursing and home care range from about $1,200 to $3,000 (a difference of 150 percent).[9] Premiums for six other policies that offer nursing, as well as home and adult day care, range from about $1,400 to $2,700 (a difference of 93 percent). From the consumer's perspective, these policies would appear similar because they offer the same basic benefits and dollar coverage.

Policyholders who obtain long-term care insurance at the lowest market price cannot be sure that the policy will remain a bargain. Under NAIC standards, insurers can increase premiums on existing policies. Insurers can thus transfer from themselves to aging policyholders a substantial portion of the risk associated with long-term care insurance; that is, insurers who incur more claims than expected can simply increase premiums.

Future Premium Increases May Become a Problem

Premium increases can place policyholders at risk of being priced out of the market at the time when they are at greatest risk for needing long-term care services. The risk of future premium increases may be significant, given that some insurers may initially underprice policies because of the extremely competitive market.[10] In fact, there appears to be considerable competitive pressure to keep prices down. For example, most insurers who recently asked for premium changes, in three states that provided us data, requested price decreases. (This included 16 of 28 price change requests.[11]) A common reason for these requests was to allow insurers to become more competitive. For 13 policies, state regulators allowed insurers to reduce prices from 10 percent to 43 percent.

But even a policyholder who bought insurance at a low initial price could face substantial price increases in the future. Low initial prices work to consumers' advantage only if insurers do not increase these prices significantly in the future. We do not know how often this will occur, but we are not encouraged by recent premium increases. We identified 12 requests for price increases in the three states where we were able to obtain such information. Arizona had 11 of the 12 requests for price increases, ranging from 15 percent to 54 percent. These requests were quite recent. Between 1988 and 1990, the state allowed increases for all 11 policies. In one example, Arizona allowed a 30 percent increase on 3 policies issued by one insurance company. The state had already granted a rate increase for 1 or more of these 3 policies.

Requiring Nonforfeiture Benefits Can Reduce Pricing Risks and Enhance Policy Value

Insurers expect that many policyholders will allow their policies to lapse. On average, insurers we reviewed expect that 60 percent or more of their original policyholders will allow their policies to lapse within 10 years; one insurer expects an 89 percent lapse rate after 10 years. In all but two policies we reviewed, policyholders forfeit, that is, lose their entire investment in premiums if they allow their policies to lapse. NAIC standards do not require insurers to provide nonforfeiture benefits (that is, the return of a portion of the reserves resulting from their premium payments).

Nonforfeiture benefits would significantly enhance the value of policies. For example, on the basis of our review of 44 policies, a consumer who purchases a policy at the age of 75 and allows it to lapse at the age of 85 will, on average, lose nearly $20,000 in premiums. For either of the two policies in our sample that offer nonforfeiture benefits, the policyholder would receive back about $12,000 to $14,000 of the $20,000.[12] The policyholder would receive nothing back on any of the other 42 policies.

Most policies sold today offer level premiums. Essentially, level premiums result in overpayment in the early years of a policy and underpayment in later years. In this way, insurers accumulate substantial reserves for payment when claims are filed. This pricing feature results in insurers accumulating substantial reserves over relatively few years. Consequently, insurers can benefit when policyholders allow their policies to lapse, unless the policies include nonforfeiture benefits.

SIGNIFICANT MARKETING ISSUES STILL TO BE RESOLVED

Consumers who purchase long-term care insurance also face risks that are inherent in new, rapidly evolving markets. Policyholders who purchased insurance policies only 2 years ago may find their coverage limited, compared with current policies. But updating their policies may not be possible. In addition, most insurers for which we had data pay high first-year sales commissions for their long-term care policies. Such commissions encouraged marketing abuses in the sale of Medigap policies and pose a similar potential problem for long-term care insurance.

State and NAIC Standards Do Not Address Policy Upgrading

Neither NAIC nor the states we visited address the issue of upgrading policies. Today, many policyholders who want to upgrade their policies may do so only with significantly higher premiums, if at all. These policyholders must meet the same requirements and terms as new purchasers. That is, they must meet the insurer's criteria for medical underwriting and preexisting conditions, as well as pay the premium for their particular age group. The premium generally more than doubles for the 10-year difference from the age of 65 to 75. None of the policies we reviewed offer the option of upgrading the policy under more favorable conditions.

NAIC Standards for Agent Commissions Optional

We also found that some insurers pay high first-year commissions for the sale of their long-term care policies. The size of commissions and the methods of payment are of concern to NAIC because high sales commissions have created incentives for abuses in the sale of other insurance policies to older people. For example, large commissions associated with the initial sale

of Medigap policies created undesirable incentives for agents to "churn" (that is, to sell) new policies to their customers. Essentially, agents received large commissions on the initial sale of such policies and small commissions on renewals. Medigap standards have been revised to reduce incentives to churn policies by limiting the size of the first-year commissions and other compensation that may be paid to a sales agent. In addition, the standards require companies to spread the total compensation over several years.

NAIC has adopted the same Medigap standards for long-term care insurance. But NAIC established the standards as an option that states and insurers should consider adopting if they identify marketing abuses. These standards stipulate that insurers should limit first-year commissions to no more than 200 percent of the commissions paid in the second year. In renewal years, the commissions are to be the same as the second year and continue at that level for a reasonable number of years.

Long-term care policies are often more expensive than Medigap policies. As a result, agent commissions can be substantial. Of 16 policies we reviewed, only 1 paid first-year commissions that would meet NAIC's optional standards. (We were unable to determine the agent commission rates for the other 28 policies in our sample.) The remaining 15 policies paid substantially higher commissions. On average, commissions were 60 percent of the total value of the first year's premium. For half of the policies, this was at least twice what is recommended under the optional standards. With one such policy, a sales agent could earn an initial commission of $2,000 (based on a 70 percent commission rate) for selling the policy to a 75-year-old.

CONCLUSION

NAIC standards have improved significantly in the last 5 years. Although state standards have also improved, many states have not adopted key NAIC standards, and insurers have not incorporated recent NAIC standards into their policies. Further, although standards and insurance policies have improved, consumers still face considerable risks in purchasing policies.

Consumers confront a bewildering array of policies made more confusing by the absence of uniform terms and definitions. As a result, it is difficult or impossible for a consumer to understand when benefits will be paid or to compare the benefits and value of policies. Consumers also risk unpredictable premium increases that can make it difficult for them to retain their policies. Yet, if consumers allow their policies to lapse, they will lose the money they invested in premiums.

While states have progressed in recent years in adopting long-term care insurance regulatory standards, many do not conform to the standards suggested by NAIC and future state action is unclear. Therefore, the Congress may want to consider enacting federal legislation--as was done with the Medigap insurance market--to establish minimum standards for long-term care insurance.

Consideration should also be given to expanding and strengthening existing standards. Specifically, consideration should be given to

-- developing more uniform definitions for long-term care services and for eligibility criteria (the absence of uniform definitions and eligibility criteria currently makes it difficult for consumers to compare policies or to assess coverage);

-- requiring nonforfeiture benefits (long-term care insurance premiums allow insurers to build substantial

reserves to meet future expenses; allowing policyholders to recover such reserves if they allow their policies to lapse would lessen their financial losses);

-- establishing minimum standards that allow consumers to upgrade coverage (because standards and policies are evolving rapidly, consumers could benefit from a method for upgrading policies that they purchased but later found to be deficient);

-- establishing minimum standards for policyholder grievance procedures (because determining eligibility for services is judgmental, policyholders could benefit from a defined grievance process to help resolve coverage disputes); and

-- requiring the same standards for agent commissions in long-term care insurance as in Medigap insurance (the agent commission structure used by some insurers provides incentives to agents that can lead to consumer abuse).

Adopting these standards will likely increase premiums. We believe, however, that they warrant consideration because they would significantly improve consumer protection in a rapidly evolving, complex market.

This concludes my testimony. I will be happy to answer any questions you might have at this time.

ENDNOTES

1. P. Kemper and C. Murtaugh, "Lifetime Use of Nursing Home Care," The New England Journal of Medicine, Vol. 324, No. 9 (Feb. 28, 1991).

2. S. Van Gelder and D. Johnson, "Long-Term Care Insurance: A Market Update." Health Insurance Association of America Research Bulletin (Washington, D.C., Jan. 1991), p. 2.

3. In general, nursing home services are defined as skilled nursing home care--nursing and rehabilitative services provided by trained health professionals on a daily basis under the orders of a physician; intermediate nursing home care--skilled nursing care provided on an occasional basis; and custodial nursing home care (also referred to as personal care)--assistance in requirements of daily living such as eating and bathing, which can be provided by people without medical skills.

4. Home care services can provide skilled nursing care by medical professionals, as well as assistance with activities of daily living such as eating and bathing, which can be provided by people without medical skills (also referred to as personal care).

5. We reviewed state laws and regulations as provided by NAIC, February 1991.

6. Excluding coverage for people with Alzheimer's disease is particularly restrictive because more than 50 percent of nursing home residents may have Alzheimer's and about 2.5 million elderly were estimated to have the disease in 1985. See Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection (GAO/HRD-89-67, Apr. 24, 1989), pp. 19, 20, and 22.

7. Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection.

8. J. Wiener and K. Harris. "High Quality Private Long-Term Care Insurance: Can We Get There From Here?" (Washington, D.C.: The Brookings Institution, May 1990), p. 11.

9. Premiums are based on coverage for a 75-year-old who obtains a policy that provides 3 years of nursing home care, begins paying $80 per day after the first 90 or 100 days of nursing home confinement, and provides no inflation protection.

10. M. Peavy, "The Price Is Right," Best's Review (Nov. 1989).

11. Of the remaining five states we visited, two did not review insurer price changes; two had requests for price changes, but did not provide us with data, and one had no requests.

12. Although this type of nonforfeiture benefit has a cash value, insurers could provide other types of nonforfeiture benefits. For example, a policy that provides reduced paid up benefits includes a reduced daily benefit, payable for the maximum length of the policy. Although the dollar amount covered daily is reduced, the types of benefits provided remain the same.

Chairman STARK. Thank you very much. First of all, just a couple of questions. Is it not somewhat unusual for GAO to recommend legislation? I think you have done so before but only in severe cases. I mean, can I interpret this as a signal? Is that fair?

Ms. SHIKLES. That is fair.

Chairman STARK. OK. Thank you. I am happy to have you do that. You know, sometimes I have to drag that out of your boss.

Ms. SHIKLES. Well I think that we studied a lot of the problems with medigap insurance. We think that long-term care insurance is much more risky, has many more problems than the medigap area, and we are concerned about it. We see the same problems cropping up.

Chairman STARK. Also, will you make the companies available for the record? Can those be added to the record?

Ms. SHIKLES. Yes, we can.

[The list of companies follows:]

INSURANCE COMPANIES REPRESENTED IN GAO REVIEW

Aid Association for Lutherans
Amex Life Assurance Co.
Bankers United Life Assurance Co.
Blue Cross of Washington and Alaska
Certified Life Insurance Co.
Combined Insurance Company of America
Consumer Service Casualty Insurance Co.
Continental Casualty Co.
Federal Home Life Insurance Co.
Great Fidelity life Insurance Co.
Great Republic Life Insurance Co.
John Hancock Mutual Life Insurance Co.
Life and Health of America
Life Investors Insurance Company of America
Mutual of Omaha Insurance Co.
Mutual Protective Insurance Co.
Northwestern National Life Insurance Co.
Old American Insurance Co.
Penn Treaty Life Insurance Co.
Pennsylvania Life Insurance Co.
Physician's Mutual Insurance Co.
Pioneer Life Insurance Company of Illinois
The Travelers Insurance Co.
Time Insurance Co.
Union Bankers Insurance Co.
United American Insurance Co.
United General Life Insurance Co.

Chairman STARK. So at future discussions people may reference those and it would be handy for us to have those.

Ms. SHIKLES. We would be happy to do that.

Chairman STARK. Thank you. I do not know if you or your colleagues are competent to comment on this but I have a sense, both from your testimony and in talking to insurance companies that actuarially this insurance is so new that the insurance companies are very uncertain. In other words, the actuaries in life insurance can probably tell how long any of us in this room will live to the day, second, hour, minute and feel that they can rely on that for their investment plans, their ratings and their rate setting.

But my sense is that the actuaries really do not know how to assess the risk in long-term care. It is new. There is not a lot of data. Can somebody comment on that?a

Ms. SHIKLES. I think that is a fair assessment, based on our discussions with actuaries we consulted.

Mr. STROPKO. I think that is very fair. One of the problems that exists is the absence of data, and NAIC is beginning to address that. However, there is still no standard data collection instrument to compile this data, so 5 years from now we are probably going to be in the same situation.

Chairman STARK. And that could account for an insurance company starting out and saying, "we are going to charge $100 a month" and then raise the premium to $200 because "this is not what we had thought." I mean, I suspect that they are plowing a lot of new ground and some of the rate increases might be on that basis.

Mr. STROPKO. I think apart from that issue, perhaps what is more of a problem is that insurers put so many restrictive provisions in their policies to cover themselves against adverse selection.

Chairman STARK. Where you found the difference in what were almost identical policies running between $1,200 and $3,000 a year, did you take into account selling costs? Is it conceivable that one person is a direct mail marketer or something that has far higher costs or lower costs or did you find that commissions ran fairly standard or uniform in a State?

Mr. STROPKO. We did not look to that detail. We did not look at the commission structure to see if that might account for it.

Chairman STARK. It occurs to me that the company could be collecting $1,200 in both those cases but the commission could vary from $200 to $1,000 depending on the marketing practices or style of the company. Hopefully we will be able to ask other panelists.

Mr. STROPKO. It will not be a $200 commission, I do not think.

Chairman STARK. OK. In your testimony, Janet, you raise a point and I am sure that our good friends from the insurance commissioners will want to comment on this later, but there is a kind of laissez-faire approach that the States are taking toward this new product. Normally States are a lot more uniform in their requirements, say of life insurance products or automobile products, and is it correct that you are suggesting here that there is not as much regulation by the State, by NAIC and States, as there are in other insurance products?

Ms. SHIKLES. Well, I think NAIC has been very vigorous, but as I mentioned in the testimony many States are lagging in adopting NAIC standards. The eight States we visited, for example, vary considerably in the extent that they have adopted NAIC standards. Long-term care insurance is a very small part of their business to start with. And about half of the eight States we visited probably have serious deficiencies in how they are regulating the product.

Chairman STARK. Who has the regulatory deficiencies?

Ms. SHIKLES. About four of the States, four of the eight that we visited. In all but one of the States, we even had difficulty compiling a list of the approved policies and finding out what policies insurers were marketing. They did not know that themselves. I mean, they had not obtained the information. About half are not

keeping information separately on complaints, so you cannot track that, and several are not reviewing rate increases or initial premiums. It is difficult to get information.

Chairman STARK. But you also indicate that many companies are subscribing to the NAIC standards. Is that in the same States where the States were not?

Ms. SHIKLES. That is correct.

Chairman STARK. Let me just play out a scenario here and say that NAIC has their act together and they are attempting to come up with some standards and selling practice regulations. Is that your understanding?

Ms. SHIKLES. Yes, it is.

Chairman STARK. And that responsible insurance companies are looking at these standards and making a good faith effort to try and conform?

Ms. SHIKLES. Yes, they are.

Chairman STARK. That leaves us with State legislators or State regulators who are being a little slow getting their act together and making the NAIC standards into law. So can I assume that less ethical companies will take advantage of this situation and benefit by lack of regulation. Is that a fair assessment of what is going on?

Ms. SHIKLES. That is a fair assessment.

Chairman STARK. And that any legislation that we do might push the States to do what you think and I suspect we might conclude as the right thing to do?

Ms. SHIKLES. And I would think the major insurers, too.

Chairman STARK. The question will come up, if it isn't broken, why fix it? And what I am trying to get across here is the idea that what is broken is the pressures on State legislatures which may prevent them from proceeding very quickly in this area.

I appreciate your testimony. We may have some more questions later. But I would like to give Mr. McGrath a chance to inquire.

Mr. MCGRATH. Thank you, Mr. Chairman.

Ms. Shikles, what percentage of the 1.6 million policies out there did you cover by your survey?

Ms. SHIKLES. I cannot answer that because the States do not know that. We pulled a sample of policies that are approved to be sold in those States. We know we have major insurers and we have insurers that just market in those States or maybe in a couple of States.

Mr. MCGRATH. Just to follow up on the Chairman's comment, some years back when we had a property and casualty insurance problem in this country in terms of its availability and cost, one of the things we found out was that there are many States that do not have adequate insurance commissioners or apparatus to monitor and regulate insurance companies.

To what extent is this a problem in this area?

Ms. SHIKLES. I do not know.

Mr. STROPKO. One of the most obvious problems I would suspect would be in the area of pricing. Some States did a much better job of monitoring the premiums and the premium rate increases than other States. At the time that we did our study, two States did not review premiums at all.

Mr. MCGRATH. I was talking more about the structure of the insurance departments within the States. As I understood it, in New York, like anything else, it is so regulated and it is so pervasive on the industry. On the other hand, I understand that there are some States that do not even have an actuary in their insurance department.

I am just wondering about adequacy. Should we allow the insurance commissioners to set their standards and to hopefully enforce those standards? My question is how adequate are these departments and commissions in the States?

Ms. SHIKLES. I cannot answer that question. We did not look at that issue. We focused on what they were reviewing in terms of long-term care insurance, what policies are being sold in the States, and whether they review policy prices. They were not keeping any data on many of these issues and in a few States where they were keeping data, we had questions about why they granted price increases. We did not review the adequacy of the State insurance role.

Mr. MCGRATH. Well, that is all well and good that standards by the industry and commissioners are being promulgated, but unless they are enforced, in my view, that has little or no effect. Perhaps I am not sure whether or not—you do mention in your testimony that the long-term care insurance polices have improved significantly in recent years and given that evidence vis-a-vis the fact that in some cases States just do not have the ability to monitor and regulate——

Ms. SHIKLES. I think enforcement is important but I think you could start with minimum standards. If all insurers had to follow the same minimum set of standards, that would address a lot of the problems.

Mr. MCGRATH. It would make constant perhaps some nationwide policies.

Ms. SHIKLES. That is right, because our review of 44 policies in the States we visited indicated that only a few policies were very good and a lot were not very good.

Mr. MCGRATH. I thank you for your testimony. It was very enlightening.

Chairman STARK. Mr. Russo.

Mr. RUSSO. Thank you very much, Mr. Chairman. The more I listen to investigations by the GAO on health care the more I am convinced I am on the right track with my universal health care coverage. The best thing to do is get the insurance industry out of the business and we will not have to worry about all these eligibility requirements and different kinds of policies and whether or not there are any hidden things we ought to worry about.

But it seems to me that half of these policies that were sold were written, as I understand it, before 1988. And by all accounts these policies were very restrictive and they were relatively a poor value for policyholders. Of the polices that were reviewed by GAO, how many allow policyholders to upgrade their policies to take advantage of new consumer protection features.

Ms. SHIKLES. Joel.

Mr. HAMILTON. None.

Ms. SHIKLES. These are all policies being sold in December.

Mr. HAMILTON. These are also policies that the States relatively recently approved for sale.

Mr. RUSSO. OK. Let me ask you, while most of the companies do not have specific exclusions for Alzheimer's disease, your testimony suggests it still could be very difficult for a person with Alzheimer's to be covered under many policies if they do not happen to have ADL impairments.

Isn't it a little unreasonable to expect consumers to know what the ADL eligibility criteria is that could prevent them from being covered under their policies if they have Alzheimer's?

Ms. SHIKLES. We think it is unlikely that a consumer would understand all the nuances of ADLs, because we found that the policies define ADLs differently and have all kinds of different related requirements.

Joel, do you want to elaborate?

Mr. HAMILTON. That is true, and it may be more important in this area for policies to include cognitive impairment as an eligibility criterion as opposed to ADLs because many people who suffer from Alzheimer's disease do not have serious ADL limitations. But we have only a few policies, albeit very few in the sample, that offer that.

That is kind of the state of the art, if you will—policies that use ADLs or cognitive impairment as eligibility criteria.

Mr. RUSSO. One of the areas that was highlighted in your testimony is the minimal oversight of premium pricing and the mounting evidence of premium increases for the so-called level premiums which people would believe would not be increased. How can consumers guard against an unanticipated rate hike given the insignificant numbers of claims filed? Upon what basis are States allowing these fairly substantial premium increases and do you think consumers appreciate the premiums are likely to increase even those these are so-called level premium policies?

Ms. SHIKLES. Well we are very worried about that. We had difficulty finding data at the State level. In addition, some States are not even reviewing premium increases.

We also found potential examples of underpricing of policies, where because of competition, insurers reduce prices. The concern here is that consumers think that they can afford to buy these policies; however, if they do, they may get hit with a big price increase later on that may force them to lapse their policies.

This is a very expensive product and that is why we are recommending that nonforfeiture of benefits be required. It does not totally solve the problem but it makes it more expensive for insurers to have high lapse rates. We also believe that it would make insurers concentrate more on their agents to make sure that the people who buy these policies understand they are expensive; they need a lot of resources to keep them up.

Mr. RUSSO. But it seems to me it would be very difficult for the consumers themselves to be on guard against all these different unanticipated rate hikes. I mean, how does the consumer get to know enough about it to be able to do this?

Ms. SHIKLES. I do not think they could.

Mr. RUSSO. You reviewed these policies and looked at how long it has taken you to sift through it all and figure them out. You think the average consumer can do that?

Ms. SHIKLES. No.

Mr. HAMILTON. Difficult to almost impossible.

Mr. RUSSO. And even their shorthand versions of explanations are to a certain extent misleading to the consumer.

Mr. HAMILTON. That is true.

Ms. SHIKLES. We had difficulty obtaining policies. If you call an insurance company, they do not want to send you the policy. They may send an agent but you really want to look at the policies and try to compare across policies, and that is very difficult. You get the marketing material but not the policy.

Mr. HAMILTON. Most of the policies, too, do not meet the NAIC standards for an outline of coverage. An outline helps to clarify policy language in simple terms.

Mr. RUSSO. You know, it is always interesting to me when I meet with some of the business people and they admit that there is something wrong with the health care system and that they need to correct it. But left to their own designs, the private sector will never correct it. It is unfortunate that they cannot deal with the problem and correct it themselves because basically if they were really interested in such a great product they would be more than happy to give you the policy so you can see what a wonderful product this is and how wonderful it is at protecting the consumer in that there are no hidden glitches in there whatsoever.

But the fact that you even had difficulty getting policies is an indication that something is hidden there and they are a little concerned about you finding it out. I just wish the private sector could do its job but unfortunately that is why Government is in here and that is why we have to enforce laws for clean air, clean water and probably eventually have to do a national health care program to be administered by the Government only because the private sector will not do its job. It is so profit motivated that it cannot deal with the problem that it needs to address.

So Mr. Chairman, I look forward to more action on health care, as you know.

Chairman STARK. It is tough to keep up with you, my friend.

I want to thank you for your work in this area. It has been great and I think that we are going to call on you for more help as we work through this problem this year and I hope that with your guidance we can perhaps find some legislation that will be useful and I hope that serves as some compensation to you, at least, for the hard work you have done.

Thank you all very much.

For our next panel we are pleased to welcome back three friends who are familiar faces in the long-term care area. Dr. Josh Wiener is a senior fellow in economics at the Brookings Institution, and he has completed a major study with Dr. Alice Rivlin on long-term care and coauthored a book, "Caring for the Disabled Elderly."

Gail Shearer is a manger of policy analysis for Consumers Union, upon whom I rely to select my automobiles and my mother relies upon them to select her medigap insurance. She has testified before this committee on long-term care insurance, on medigap in-

surance, and is a protector and friend of the consumers in this country.

Dr. Stan Wallack is from the Heller School at Brandeis University and recently has completed a study for the Health Insurance Association of America on the impact of long-term care financing proposals on private insurance.

I want to welcome the panel, the witnesses, here today and ask if you would mind proceeding in the order in which I introduced you. You can expand on your testimony or summarize it in any way you are comfortable.

Josh, why don't you lead off?

STATEMENT OF JOSHUA M. WIENER, PH.D., SENIOR FELLOW, THE BROOKINGS INSTITUTION

Mr. WIENER. Thank you, Mr. Chairman. It is a pleasure to be here today. American society uses private insurance to protect against loss of catastrophic events such as hospitalization, automobile accidents, home fires, theft and untimely death. Insurance against the potentially devastating cost of long-term care however is still relatively rare. Nonetheless private long-term care insurance is a growing and rapidly changing market. Over time, the policies have improved substantially. While many policies in force still have substantial restrictions, new policies provide significantly better coverage. Despite these improvements, most policies marketed today still have major deficiencies.

In testimony today I would like to make five points. The first is that good quality private long-term care insurance is expensive. While there is no technical reason why private long-term care insurance cannot offer better coverage than what is currently on the market today, to do so will significantly increase premiums.

Using our pricing model at Brookings, we estimate that a policy that covers 4 years of nursing home care and 4 years of home care, indexes indemnity benefits for inflation on a compound basis and has an actuarily fair nonforfeiture value would cost approximately $2,600 a year at ages 65 to 69.

The debate over the affordability of private long-term care insurance in fact has been flawed by a lack of agreement over what kind of policy people are assumed to be buying. If what people mean by saying that individuals can afford private long-term care insurance is that they can buy a policy like I outlined above, then the proportion of the elderly that can afford private long-term care insurance is almost certainly less than we and others have estimated because we and others have used lower premiums reflecting less coverage.

My second point is that premium prices vary widely due to different actuarial assumptions. One of the principal barriers to long-term care insurance is that the need for long-term care is needed principally by the very elderly, those age 85 and older. The very long time horizon between initial purchase of the insurance and ultimate use of nursing home and home care involves great uncertainty and financial risk. This uncertainty is reflected in the variability of the market place. For example, in 1990, the premiums of Midland's private long-term care insurance policy at age 65 to 69 is

71 percent higher than a comparable policy by AMEX which is in turn 60 percent higher than a comparable CNA policy.

It is likely that some current policies will reap great profits for their companies while others could lead to great losses. It is impossible, however, to say with certainty which of these premium estimates are more accurate. But they cannot all be right.

Two adverse consequences flow from financial losses for policies that are underpriced. First some companies may lose substantial sums of money, threatening the financial solvency of the companies. However, what is more likely is that consumers may face substantial rate increases designed to reduce the loss by insurers. To circumscribe the amount of financial risk, insurers may ultimately limit the number of policies they sell.

My third point is that improving inflation adjustments is the most urgent consumer need today. Although the NAIC strengthened the model regulations in December 1990, inflation protection remains a contentious consumer protection issue. There is little doubt that few consumers understand how devastating inflation is to the policy's purchasing power.

Anecdotal evidence suggests that consumers want very high initial indemnity values but then are reluctant to pay for consumer protection. Insurers are beginning to offer compound inflation adjustments as required by the new NAIC model regulations. The NAIC model regulation now requires that insurers offer consumers either an inflation adjustment compounded at a minimum of 5 percent annually or the right to increase the policy's indemnity level by an amount comparable to the compound adjustment.

Critically, the revised model requires only that the compound adjustments be available as optional riders. Insurers are not prohibited from selling unindexed or simple-indexed policies. In order to lessen the price impact of compound adjustments on premiums, some insurers have put limits on the number of years of indexing or they discontinue indexing once a policyholder reaches a given age. This is inadequate. Unlimited compound adjustments should be required of all policies.

My fourth point is that high lapse rates are a major problem but mandating nonforfeiture benefits is only a partial solution. For a variety of reasons, not all persons who initially purchase a policy will make premium payments until death. Although not much data is available, it is commonly assumed in the insurance industry that about half of all insureds will drop their policies.

It is important however to distinguish between short term and long-term lapses. The fact of the matter is that most of the adverse publicity concerns lapses within the first 5 years. Short-run lapses are better addressed by changing agent incentives to avoid churning and by having higher overall standards so that policies are not being constantly changed by insurers thus enticing customers to drop old policies and buy new ones.

Despite the fact that nonforfeiture benefits are not a panacea, we believe that they should be required. If lapse rates are low, then the benefit can be added at little cost. If lapses are high, then they are an essential part of consumer protection.

Fifth and finally, Federal regulation of long-term care insurance is necessary. In our recommended strategy, the Federal Govern-

ment would substantially strengthen the NAIC standards and then mandate them nationally. All insurers would be required to meet the standards. States could exceed these minimum standards if they wished.

The advantage to this approach is that it ensures that all policies will be of high quality. This will strike most in the insurance industry as unduly intrusive, but the bulk of what we believe to be necessary requirements including providing inflation protection on a compound basis, fully describing how the activities of daily living are to be assessed, making sure that if offered, home care benefits can actually be obtained and providing decent nonforfeiture values, are critical to making sure that benefits are nonillusory.

In sum, there has been a lot of improvements, but we think Federal regulation is necessary.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JOSHUA M. WIENER AND KATHERINE M. HARRIS THE BROOKINGS INSTITUTION*

American society uses private insurance to protect against loss from catastrophic events such as hospitalization, automobile accidents, home fires, theft and untimely death. Insurance against the potentially devastating costs of long-term care, however, is still relatively rare. Nonetheless, private long-term care insurance is a growing and rapidly changing market. A survey conducted by the Health Insurance Association of America found that the number of companies selling long-term care insurance increased from 75 in 1987 to 134 in 1990. Moreover, the number of insurance policies ever sold increased from 815,000 in 1987 to 1,650,000 in 1990. The number of policies currently in force is about 1,000,000. A very small, but growing employer-sponsored market is now developing.

Faced with a lack of actual claims experience with an insured population, insurers initially tried to protect themselves against financial loss by imposing strict limitations on what policies covered. The net effect of these restrictions was to substantially lessen the probability that a person who used nursing home or home care would actually receive insurance benefits. These so-called "first generation" private long-term care insurance policies were roundly criticized by consumer groups and academics.

Over time, the policies have improved substantially. While many policies in force still have substantial restrictions, new policies provide significantly better coverage. In particular, among newer policies, prior hospitalization requirements are eliminated, policies are guaranteed renewable, Alzheimer's Disease is explicitly covered, all levels of nursing home care are covered, a bit more home care is covered, and indemnity levels are at least partly indexed for inflation. It is important to note that these changes are largely in response to state regulatory requirements and market demand by consumers and not because insurers have gained experience in paying claims. Despite these improvements, most policies marketed today still have deficiencies.

In our testimony today, we would like to make five main points:

- Private long-term care insurance that does not have undesirable coverage restrictions is very expensive. As a result, the affordability of private long-term care insurance is less than has been previously estimated.
- Because of the long time span between initial purchase of most long-term care insurance and its ultimate use, private long-term care insurance is a uniquely risky product to sell. The extremely wide variation in existing premiums illustrates this uncertainty. Some policies will be profitable, while others will require massive premium increases to avoid large losses.
- The most important defect in existing policies is that indemnity levels do not increase on a compound basis. As a result, the buying power of most policies erodes dramatically over time.
- High lapse rates are a serious problem in long-term care insurance, but one that can be only partly addressed by requiring the provision of nonforfeiture benefits.
- Although they are not without their own set of problems, federal minimum standards for private long-term care insurance are desirable. These minimum standards should set rigorous standards for the sale of all insurance products.

Good Quality Private Long-Term Care Insurance Is Expensive.

While there is no technical reason why private long-term care insurance cannot offer better coverage than what is currently on the market, to do so will substantially increase premiums. Using the Brookings-ICF Long-Term Care Financing Model, we estimate that the annual premium for a private insurance policy that covers four years of nursing home care and four years of home care, indexes indemnity benefits for inflation on a compound basis

* **These opinions are those of the authors and should not be attributed to other staff members, officers or trustees of the Brookings Institution.**

and has an actuarially fair nonforfeiture value is $2,607 a year at ages 65-69 (Table 1). Indexing indemnity benefits for inflation dramatically increases premiums, but it is essential to maintaining a nonillusory benefit.

The debate over the affordability of private long-term care insurance has been flawed by a lack of agreement over what kind of policy people are assumed to be "buying." Private insurance policies can be designed to fit any affordability criteria. The more restricted the benefits, the lower the premiums, the higher the affordability estimates will be. Conversely, the richer the benefits, the higher the premium, the lower the affordability estimates will be. Earlier analyses were based on policies that provided less coverage and had lower premiums. If what people mean by saying that individuals can afford private long-term care insurance is that they can buy a policy that covers a fairly long period of use, maintains its purchasing power over time, covers home care as well as nursing home care, and whose price does not depend on high percentages of insureds dropping their policies, then the proportion of elderly who can afford private long-term care insurance is almost certainly less than we and others have previously estimated.

Premium Prices Vary Widely Due to Different Actuarial Assumptions.

One of the principal barriers to the supply of long-term care insurance is that long-term care is needed principally by the very elderly, those age 85 and older. The very long time horizon between initial purchase of insurance and ultimate use of nursing home and home care involves great uncertainty and financial risk. A policy bought at age 65 probably may not be used until age 85, 20 years into the future. A policy bought at age 45 probably will not be used for 40 years. Unforeseen changes in disability or mortality rates, nursing home and home care use patterns, lapse rates, or the rate of return on financial reserves can rapidly change a profitable policy into an unprofitable one.

To test the sensitivity of insurance premiums to the interaction of a number of pricing factors, a constellation of reasonable assumptions was constructed for a "high" and "low" premium for the same set of benefits. The differences are dramatic (Table 2). For the 65-69 age cohort, the "high" premium of $3,063 a year is two and a third times the "low" premium of $1,324 a year. This variability is reflected in the current marketplace. For example, the 1990 premium of Midland's long-term care insurance policy at ages 65-69 is 71 percent higher than a comparable AMEX policy, which is 60 percent higher than a comparable CNA policy.[1]

It is likely that some current policies will reap great profits for their companies, while others could lead to great losses. It is impossible to say with certainty which of these premium estimates are more accurate, but they cannot all be right. Two adverse consequences may flow from financial losses for policies that are underpriced. First, some companies may lose substantial sums of money, threatening the financial solvency of the company. Or, more likely, consumers may face substantial rate increases designed to reduce the loss by insurers. To circumscribe the amount of their financial risk, insurers may ultimately limit the number of policies they sell.

Improving Inflation Adjustments is the Most Urgent Consumer Need.

Although the National Association of Insurance Commissioners (NAIC) strengthened its model regulation in December 1990, inflation protection remains a contentious consumer protection issue. Without adequate inflation adjustment, policyholders may find that the benefits provided by the policy are not sufficient to cover long-term care costs without depleting assets or relying on Medicaid. Unlike acute care health insurance which links benefits to service costs or charges, almost all private long-term care

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1. The policies pay $60 per day, have a 100 day deductible, provide four years of nursing home coverage, and are unindexed for inflation.

insurance provides fixed indemnity benefits. Because in most cases there is a long period of time between initial purchase of a policy and its eventual use, inflation adjustment of the indemnity value is absolutely critical to retain the benefit's purchasing power. Relatively few of the more than one million policies currently in force provide any, let alone adequate, inflation protection.

According the Health Care Financing Administration, nursing home revenue per day increased by an average of more than 3 percentage points above the Consumer Price Index between 1977 and 1988. Therefore, as important as inflation adjustments are to the elderly, they are absolutely essential for policies sold to active workers, where there could easily be 30 to 40 years between initial purchase and use of long-term care services. Assuming that nursing home care costs rise at 5.5 percent per year, a consumer who purchases an unindexed policy today at age 50 with a $60 daily benefit and uses it at age 85 would have the same purchasing power as a person trying to buy long-term care today with $10 daily benefit.

Insurers typically deal with the inflation issue in one of three ways. First, some companies offer policies where the insured can periodically purchase increased benefits without providing evidence of insurability or good health status. This additional coverage is purchased, however, at the new attained age and will cost more--perhaps considerably more, depending on the new age--than if the coverage was bought at an earlier period. For active workers, this approach requires them to actively monitor nursing home prices and consciously decide every few years to buy more coverage. This approach makes an adequate benefit appear far less expensive than it actually will be. It also ignores the fact that the real incomes of the elderly are either stable or decline as individuals age because private pensions are not fully adjusted for inflation, surviving spouses do not usually receive full pension benefits after the pension-earning spouse dies, and because the elderly slowly use up their savings as they age. Thus, the elderly will have to use increasingly higher percentage of their fixed income to maintain the policy's purchasing power.

Second, some companies offer "simple" inflation adjustments where the benefit level increases by a fixed amount each year, usually 5 percent of the initial indemnity value for some period of time, often 20 years. For example, a policy that initially pays $60 per day in a nursing home will increase by $3.00 per year.

Although many consumers undoubtedly confuse simple adjustments with increases that are compounded annually, the benefits are dramatically different. For a person who purchases a policy at age 55, a simple inflation adjustment in effect for 20 years will increase the benefit level by only 100 percent at age 85. In contrast, if the price of long-term care services increases at a compounding rate of 5 percent per year, the price of long-term care would have increased by 327 percent over the 30 years. Thus, the policies currently in force that use simple adjustments do not adequately adjust for inflation.

There is little doubt that few consumers understand how devastating inflation is to the policy's purchasing power. Anecdotal evidence suggests that consumers want very high initial indemnity values but are reluctant to pay for inflation protection. Indexing the benefit to full nursing home and home care price increases is clearly risky for insurers because they have no way of knowing what these future costs will be. Moreover, insurers are also reluctant to offer policies that increase benefits at a fixed percentage compounded annually because doing so dramatically increases the premiums, thus reducing the potential market. For example, the Brookings premium pricing study estimates that a four-year, unindexed policy covering both home and nursing home care would cost $1,103 when purchased at age 65-69. A similar policy with indemnity benefits compounded at 5.5 percent per year for the life of the policyholder would cost $2,607.

Third, insurers are beginning to offer compound inflation adjustments as required by the new NAIC model regulations. The NAIC model regulation now requires that insurers offer consumers either an inflation adjustment compounded at a minimum of 5 percent annually or the right to increase the policy's indemnity level by an amount comparable to a compound adjustment.

Importantly, the revised model requires only that compound adjustments be available as optional riders. Insurers are not prohibited from selling unindexed or simple indexed policies. In order to lessen the price impact of compound adjustments on premiums, some insurers have put limits on the number of years of indexing or they discontinue indexing once a policy holder reaches a given age. This is inadequate. Unlimited compound adjustments should be required of all policies.

High Lapse Rates Are a Major Problem, but Mandating Nonforfeiture Benefits is Only a Partial Solution.

If long-term care insurance is purchased at age 65, premiums may have to be paid for 20 years or more until death. If purchased at younger ages, the insured may have to pay premiums for 40 years or longer. For a variety of reasons, not all persons who initially purchase a policy will make premium payments until death. Although not much data is available, it is commonly assumed in the insurance industry that about half of all insureds will drop their policies within the first five years. It is unknown what proportion of these lapses represent decisions by insureds to switch to a better policy with fewer restrictions.

The public policy problem is that virtually all policies have level premiums designed to build up substantial reserves in the early years for payout in the later years. Consumers who pay in during the early years and then decide not to renew their policies will have overpaid during the period that the policy was in effect for the protection actually received. A complicating factor is that while policies sold on a level premium basis do not have scheduled premium increases, the insurance companies universally reserve the right to raise premiums for all persons in a class, if necessary, sometime in the future.

The higher the insurer's lapse rate assumptions, the lower the premiums will be because fewer benefit payments will be made on behalf of purchasers. Since insurers will receive premium payments without ever having to pay claims, the premiums paid by the policyholders who lapse can subsidize the premiums of the policyholders who do not lapse. Some actuaries have argued that some companies are substantially underpricing their policies to gain a larger market and that premiums will be raised in the future, creating a high lapse rate. Under these circumstances, companies could make windfall profits and the insured would be left both overcharged and without coverage.

Lapse rates would be a less significant consumer protection issue if insurers would offer nonforfeiture benefits. Nonforfeiture benefits allow policyholders who drop their policies to finance a residual benefit with a portion of their accumulated reserves. While nonforfeiture benefits are required in pre-funded life insurance products, few insurers offer them on long-term care products.

It is important, however, to distinguish between short-term and long-term lapses. The fact is that most of the adverse publicity concerns lapses within the first five years. Short-run lapses are better addressed by changing agent incentives to avoid churning and by having higher overall standards so that policies are not being constantly changed by insurers thus enticing consumers to drop old policies and buy new ones. Although short run lapses have received the most attention, nonforfeiture benefits are most appropriate for people who have paid premiums for a substantial period of time, perhaps five to ten years. Only at that point will consumers have built up enough reserves to finance a meaningful nonforfeiture benefit.

Despite the fact that nonforfeiture benefits are not a panacea, we believe that they should be required. If lapse rates are low, then the benefit can be added at little cost. If lapse rates are high, then they are an essential element of consumer protection, even though they may add substantially to the costs.

From a public policy perspective, noncash nonforfeiture benefits are preferable to cash benefits. Although not technically easy to calculate, nonforfeiture values should also be as actuarially fair as possible. The noncash nonforfeiture benefits that have been proposed include reduced paid

up benefits, where the indemnity level is reduced, or extended term benefits, where the policy remains in effect for some period of time after the lapse. Current cash nonforfeiture benefits, where provided, are poor values and are generally limited to the return of some portion of the premium without any interest earnings. If insurers are seeking favored tax treatment, then there is a dilemma. The better the cash value, the more long-term care insurance looks like a savings tax shelter rather than health insurance.

Federal Regulation of Long-Term Care Insurance is Needed.

Should the federal government regulate long-term care insurance? There are compelling arguments on both sides of the issue. On one hand, the federal government may be able to improve upon existing NAIC standards and reduce variation in state regulation. Despite the progress that has been made, the current NAIC model sets forth only minimal standards. As a result, there is no guarantee that even policies that meet the NAIC standards are of high quality. There is also no uniformity in the speed with which state legislatures address even these minimal NAIC standards and in the stringency of enforcement. In addition, proponents of federal regulation also argue that it is inefficient for insurers to modify these policies to meet individual state requirements. Finally, the regulation of medigap policies sets a precedent for federal regulation of insurance products marketed to the elderly. There have already been reports of fraudulent sales practices of the type that led Congress to pass the Baucus Amendment setting minimal standards for Medicare supplemental insurance.

On the other hand, federal intervention is not a panacea. The federal government may prove more rigid than the NAIC in adapting to desirable product improvements. For example, lapse rates and technical issues of activity of daily living measures were barely perceived as serious issues three years ago. It is only recently that the NAIC has begun to address nonforfeiture benefits. Further, the development of federal standards does not guarantee that more adequate resources for enforcement will be made available at either the state or federal level. The result of federal intervention may be a set of impressive standards with uneven compliance and enforcement.

Despite possible drawbacks, federal regulation of long-term care insurance is desirable, if for no other reason than there are some states that will never adopt even minimally acceptable standards without a federal mandate. As of late 1990, almost all states have passed some form of long-term care insurance legislation. However, only 28 states have issued regulations. Only 14 states require any form of inflation protection and only 12 states have any home care coverage standards.

There are three broad options for federal involvement. First, the federal government could adopt a voluntary, medigap-like certification strategy with minimal standards much like the current NAIC model statute and regulation. This incremental strategy would not impose substantial new requirements since most existing policies already meet these standards. The advantage of this approach is that some states would strengthen their regulations and some insurers might improve their policies to meet these higher standards, improving the average product. It would also establish the principle of federal involvement and open the door to raising the minimum standards in the future. However, this approach could mislead consumers into thinking that policies with the "government stamp of approval" were high quality policies. In addition, as more states adopt the NAIC model statute and regulation and as the NAIC improves its standards over time, this intervention may not add a great deal to what would have occurred under the current regulatory system without any federal standard.

Second, the federal government could adopt a voluntary certification strategy that set such stringent standards that few policies current on the market would meet them. Under this scenario, policies not meeting this standard could still be sold so long as they met state regulatory standards, but they could not claim to deserve a "government seal of approval." The advantage of this approach is that any policies that met the standards would truly deserve recognition as high quality policies. The standards would

send a strong message to consumers and insurers on what constitutes a good policy. However, the voluntary standards may be set so high as to be considered irrelevant by insurers and, therefore, not an important influence on policy design.

Third, and our recommended strategy, the federal government could substantially strengthen the NAIC standards and then mandate them nationally. All insurers would be required to meet the standards. States could exceed these minimum standards if they wished. The advantage of this approach is that it ensures that all policies will be of high quality. This will strike some in the insurance industry as unduly intrusive, but the bulk of what we believe to be necessary requirements--including providing inflation protection on a compound basis, fully describing how the activities of daily living are to be assessed, making sure that, if offered, home care benefits can actually be obtained, and providing decent nonforfeiture values, are critical to making sure that benefits are not illusory. The risk of this approach is that insurers might decide that the compliance costs are too high and drop out of the market. Regulatory rigidity may also be a problem.

Conclusion

Private insurance is a major new initiative in the reform of long-term care financing. Companies who write these policies and the state insurance regulators who regulate them are handicapped by lack of experience with how the insured and the long-term care delivery system will respond to insurance. Both companies and regulators face a trade-off between protecting consumer interests and encouraging a financially risky new product.

Over the last five years, there has been a marked improvement in the quality of private long-term care insurance policies on the market and in the stringency of state regulation of these policies. Unfortunately, many states have failed to upgrade their regulations to protect consumers. The private long-term care insurance market is now mature enough so that more than minimum national standards should be adopted. These standards should build on the current NAIC model regulations, but considerably exceed them. Proper resolution of almost all of the regulatory issues discussed above are essential to ensuring that consumers actually get the benefits they think they are purchasing. While consumers should have options and choices, they should not be required to choose among policies that promise benefits they will not provide.

TABLE 1

Estimated Annual Premiums for Prototype Private Long-Term Care Insurance Policies: Length of Covered Nursing Home and Home Care

AGE OF PURCHASE	2 YEARS	4 YEARS	UNLIMITED
40-44	$ 574	$ 829	$1,101
50-54	777	1,120	1,479
60-64	1,251	1,809	2,373
65-69	1,799	2,607	3,413
70-74	2,326	3,427	4,699
75-79	2,747	4,073	5,366
80-84	3,073	4,800	6,860

- Coverage = Number of years of covered nursing home care after a 60 day deductible and number of years of covered home care after a 30 visit deductible.
- Reimbursement rate = Pays $60 per day for nursing home care and $30 per visit for home care.
- Inflation adjustment = Benefits increase at 5.5 percent per year, 1.5 percent above long-run general inflation.
- Lapses = 0 percent, which is equivalent to a forfeiture value equal to the full asset share.
- Discount rate = 7.5 percent, 3.5 percent above general inflation over the long run.
- Moral hazard = 80 percent for home care; 0 to 20 percent after 10 years for nursing home care.
- Individual product = 70 percent loss ratio.
- Type of premium = Level.

TABLE 2

Annual Premiums for Prototype Private Long-Term Care Insurance Policies: Extreme Combinations

AGE OF PURCHASE	LOW*	HIGH+
40-44	$ 233	$1,157
50-54	400	1,461
60-64	814	2,207
65-69	1,324	3,063
70-74	1,909	3,859
75-79	2,396	4,503
80-84	3,180	5,087

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* Low = 4 years of nursing home care after a 60 day deductible, 4 years of home care after a 30 day deductible, payment of $60 for nursing home care and $30 for home care, indexed at 5.5 percent per year, high lapse rate, 4.5 percent discount rate. Moral hazard: 60 percent for home care; 0 to 10 percent after 10 years for nursing home care.

+ High = 4 years of nursing home care after a 60 day deductible, 4 years of home care after a 30 day deductible, $60 for nursing home care and $30 for home care indexed at 5.5 percent per year, zero lapse rate, 2.5 percent discount rate. Moral hazard: 100 percent for home care; 0 to 25 percent after 15 years for nursing home care.

Chairman STARK. Thank you very much, and Gail.

STATEMENT OF GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION

Ms. SHEARER. Mr. Chairman and Mr. Russo, Consumers Union appreciates the opportunity to present our views on the issue of private long-term care in the insurance market. We have found that the private long-term care insurance market is not serving consumers very well.

Some of the problems are fixable. State insurance regulators have it in their power to develop regulations to ensure that purchasers are protected against the erosion of benefits by inflation, unscrupulous marketing and claims handling practices, unfair pricing practices, possible insurer insolvency, the absence of nonforfeiture values, and other risks of this market.

Perhaps they will even take steps to simplify the market and make it possible to compare premiums for similar policies to prevent the abuses that occur because of the complexities of this market or because consumers cannot possibly understand the restrictions contained in the fine print. But we have also concluded that the private long-term care insurance market alone cannot solve the Nation's long-term care problem.

The private market cannot help people who need long-term care because of a birth defect or tragic accident early in life. It cannot help people whose health conditions place them at high risk of needing long-term care and therefore cannot qualify for a policy. And it cannot help people who simply cannot afford the high cost of a policy year after year.

With this in mind, we recognize that as long as there is a market for private long-term care insurance, both Congress and State insurance regulators should work to ensure that it serves consumers well. In my testimony I will elaborate on some of the key concerns that we have.

We strongly support an increased congressional role in establishing standards for this market that will assure consumers across the entire country that they will get good value for their premium dollars spent on long-term care policies.

I will briefly summarize some of the key problems. Inflation—policies do not protect consumers adequately against erosion of benefits by inflation which can have a major impact over the course of 20 to 30 years. High lapse rates without refunds—companies assume that 5 to 20 percent of their policyholders will let their policies lapse each year.

Over 25 years, a policyholder could have a sizeable equity of $60,000 in a policy. If he or she drops the policy simply by failing to pay a premium, all of the equity is lost.

Unfair pricing practices—so-called level premiums can be increased. Consumers buy the policy without knowing what it will cost in the future.

Poor terms on policy upgrades—if a company improves its policy, purchasers of early generation policies are like guinea pigs. They are typically not given the opportunity to upgrade their policy with favorable terms.

Market place confusion—comparing alternative long-term care policies makes shopping for a medigap policy look like a trip to the beach. Differences between alternative policies are hidden in the fine print. The policies are full of their own loopholes which are designed to protect companies and not consumers from risk.

Agent abuses—agents are confused about these policies and often make representations that are not true. For example, the premiums will not increase or that the policy they are selling is the best on the market. The commission structure, paying first year commissions of 50 to 80 percent, discourage the agent from taking the consumer's long-term interest in mind.

Varying ADL triggers—companies use different scales and varying triggers to determine qualification for benefits. These are confusing and often call into question whether the consumer gets a fair determination from the company. The company has strong incentives to deny claims.

In preparing for this hearing I collected a few samples of long-term care policies and I would like to share with you some examples of where policy terms do not protect consumers adequately.

Policy A includes an optional automatic benefit increase provision of "5 percent of the original amount each year," with the increase ending at age 85 just as the policyholder's risk of using the benefits increases. The option is not available to applicants who are age 80 or older. This is an example of the use of a simple, not compound, inflation rate and the inflation benefit is optional, not a part of the basic package.

Policy B offers a home health care benefit that appears to look pretty good at first, $35 for each covered visit by a nurse or qualified therapist, $25 for each covered visit by a home health aid, $30 for each covered adult day care visit. However the fine print in the outline of coverage limits this benefit severely. It requires among other things that "your physician who orders your plan of treatment must certify that you would require an inpatient stay in a nursing home if the home health care were not provided."

Most people, I believe, assume that home health care benefits could be provided in situations that are less severe than those actually requiring placement in a nursing home. Another concern about this policy is the level of benefit for nursing home care, $50 per day.

While a good feature of this policy is that the benefit is automatically increased at a compound rate of 5 percent per year at no extra cost, it is important to note that $50 covers about 41 percent of the present cost of a nursing home day in Washington, D.C.

Policy C has an automatic benefit increase option based on a 5 percent simple increase not a compound adjustment. Like Policy B, its home health care benefit is limited by the requirement that "without such plan, hospital, licensed nursing care facility or other institutional confinement would otherwise be required."

This policy could further limit home health care requirements through its definition of what a home health care plan is, which includes the following:

A home health care plan must include at least, one, part-time or intermittent nursing services rendered by a licensed registered nurse; two, part-time or intermit-

tent home health aid services and rehabilitative physical, speech, respiratory or occupational therapy rendered by a licensed therapist.

I am sure that many people who may need home health care would not be in need of the type of therapy required in this definition. In fact, it is likely that many policyholders who would meet this requirement would qualify for Medicare benefits.

Policy D provides an interesting variation on inflation coverage. The front page advises, "Please note, there are two pages numbered 9, one for each inflation protection feature." One page 9 shows a rather typical though limited simple inflation adjustment option that increases the benefit by 5 percent, the initial amount, for a period of 20 years. The other page 9 describes an inflation index that baffles me.

I will not read the full details, but let me just say the formula gives me pause. And if it gives me pause—I have an undergraduate degree in math and economics and a very quantitative graduate degree—then it certainly raises questions about the ability of other people to make informed decisions.

Perhaps as important as what is in these policies is what is not in them. None of the policies I reviewed had any provision for providing any benefits to policyholders who dropped their policy. And this is a very serious omission. And this small selection of policies can only begin to give you the idea of the extent of variation and confusion that faces the purchaser in this market.

Thank you very much for the opportunity to present our views.

[The prepared statement follows:]

TESTIMONY OF GAIL SHEARER
MANAGER, POLICY ANALYSIS
CONSUMERS UNION

Mr. Chairman and members of the Subcommittee, Consumers Union[1] appreciates the opportunity to present our views on the issue of the private long-term care insurance market. We commend Chairman Stark both for holding this important hearing and for his recognition of the limited potential of the private insurance market to solve the nation's growing long-term care problem. While Consumers Union's testimony today does not address the bigger picture question of how to design the best long-term care system for this country -- a system that would build on the role of the government -- we appreciate the Chairman's concern for protecting the hundreds of millions of Americans who will never benefit from a private long-term care insurance policy.

The issue of long-term care has been a high priority for Consumers Union during the past three years both in terms of the product ratings in **Consumer Reports** and our advocacy efforts. In May 1988, **Consumer Reports** rated 53 private long-term care insurance policies. In our June 1991 issue, **Consumer Reports** will publish the results of a new in-depth analysis of the long-term care policies that are presently on the market. The market has grown and changed significantly during the past three years, and the new article is sure to contain information that will be useful to this Subcommittee's investigation. I will be sure to provide copies of the article to the Subcommittee as soon as they are available. With regard to public policy advocacy on long-term care, our Washington Office issued the report Long-Term Care: Analysis of Public Policy Options in January, 1989. In addition, we have been actively involved in both reviewing and developing proposals before the Congress and state regulators to improve the functioning of the private long-term care insurance market.

We have found that the private long-term care insurance market is not serving consumers very well. Some of the problems are fixable: state insurance regulators have it in their power to develop regulations to insure that purchasers are protected against erosion of benefits by inflation, unscrupulous marketing and claims handling practices, unfair pricing practices, possible insurer insolvency, the absence of nonforfeiture values, and other risks of this market. Perhaps they will even take steps to simplify the market and make it possible to compare premiums for similar policies, to help prevent the abuses that occur because of the complexities of this market or because consumers can not possibly understand the restrictions contained in the fine print. But we have also concluded that the private long-term care insurance market alone can not solve the nation's long-term care problem. The private insurance market can not help people who need long-term care because of a birth defect or tragic accident early in life. It can not help people whose health conditions place them at high risk of needing long-term care and therefore can not qualify for a policy. And it can not help people who simply can not afford the high cost of a policy, year after year. In my testimony, I will elaborate on some of the key concerns that Consumers Union has about the private long-term care insurance market. We strongly support an increased Congressional role in establishing standards for this market that will assure consumers across the entire country that they will get good value for their premium dollars spent on long-term care policies.

Inadequate inflation protection. Failure to adequately

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[1]Consumers Union is a nonprofit membership organization, chartered in 1936 under the laws of the State of New York to provide information, education, and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of **Consumer Reports**, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants, and fees. In addition to reports on Consumers Union's own product testing, **Consumer Reports**, with approximately 4.9 million paid circulation, regularly carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

long-term care policies. I am unable to think of any other insurance product or financial investment where the failure to pay a premium can lead to the loss of equity on this scale. Imagine the outrage consumers would feel if they lost the equity in their home simply by not paying the mortgage for a month.

Unfair and Predatory Pricing practices: Another deficiency of the private market is unfair pricing practices. Most long-term care policies are "level-premium" policies. "Level premium" does not mean that premiums will stay level. It means that premiums will not **automatically** increase each year as the policyholder ages. Companies with "guarantee renewable" policies are free to increase the so-called level premium if they increase it for everyone else in the state with the policy. This amounts to "bait, lock-in and switch" for consumers, who are forced to make a purchase decision without knowing the cost in future years. This leads to strange incentives for insurance companies. Companies have a strong incentive to underprice the policy initially in order to attract customers, and then raise premiums in later years, after consumers are locked in.

Companies that deliberately underprice their premiums (to undercut the competition) and then raise them in later years create one type of consumer victim. Companies that continue to underprice their product risk insolvency, creating another type of consumer victim, whose long-term care claims can not be honored. A comprehensive reform of the long-term care market would have to address the system that protects consumers in the event of insolvency.

Post-claims Underwriting. Unscrupulous insurance company and agent practices have also created major problems for consumers. The October 1989 issue of **Consumer Reports** tells the story of three victims of the troubling practice of "post-claims underwriting" -- the practice of checking a policyholder's medical history only after a claim is filed, instead of when an application is taken. It is very difficult for a consumer to predict at the time of purchase whether the company is likely to honor a legitimate claim made in the future.

Poor terms on Policy Upgrades: The long-term care industry is relatively young, and companies are continuing to make fundamental changes in their policy terms, in part because of new state regulations. For example, companies might add an inflation benefit, a nonforfeiture benefit, or might eliminate a prior hospitalization requirement. In most cases, existing policyholders can not benefit from these improvements, unless they drop their existing policy (losing possibly tens-of-thousands of dollars of equity) and buy the new policy. Since the policyholder would be several years older, he or she can expect to pay a higher premium for the basic policy than he would if he had continued his original policy.

Marketplace Confusion. Comparing alternative long-term care policies makes shopping for a Medicare supplement insurance policy look like a trip to the beach. The definitions of terms -- skilled nursing facility, "licensed nursing care facility," "custodial care," "medically necessary," "home health care benefit," "inflation benefit," "nonforfeiture benefit." All of these -- and scores of other -- terms can have a broad range of definitions. Terms like "inflation benefit" and "nonforfeiture benefit" can have dramatically different values because of subtle differences in assumptions made by actuaries. These figures can easily be manipulated and are very difficult for consumers to understand. It is virtually impossible for consumers to make a comparison of **similar** long-term care insurance policies because the terms -- and indeed the implications of the fine print in the definitions -- vary so widely. The long-term care market should be simplified through standardization of definitions and the development of standard benefit packages which would gradually be phased in.

Agent abuses: When **Consumer Reports** rated long-term care policies in 1988, our reporter found "confusing presentations from agents who were either ignorant of the provisions in their policies or who deliberately misstated them." For example, agents said that premiums would never increase, when in fact they could. Other

agents declared policies were best, even one policy that ranked near the bottom of **Consumer Reports** rating. A recent **Inside Edition** shows that agents continue to make these same misrepresentations when trying to sell policies. Most consumers are not in a position to judge the truth of what the agent says, and desperately need tougher regulation of agents as well as an objective source of information and advice.

Another agent-related problem is the commission structure. Front-loaded commissions -- hefty commissions in the range of 50 to 80 percent of the first year premium -- are prevalent in this market. From the agent and company viewpoint, high first-year commissions reward the agent's hard work that is needed to close a sale. From the consumer perspective, they provide the agent with a strong financial stake in making a sale that does not necessarily serve the long-term interests of the consumer. When I have suggested a more level commission structure, the response from companies is: but then the agent loses financially if the policy lapses after one or two years. And this is my point -- the agent (and, for that matter, the company) should have financial incentives to address the **long-term** needs of consumers.

Varying ADL Triggers: Many policies use activities of daily living scales to determine eligibility. The actual scales vary from company to company, with some using the Katz ADL scale (5 activities: eating, bathing, moving from one location to another, going to the toilet, and dressing). Others use 6 ADLs, including taking medication as a sixth activity. Another scale sometimes used includes measures for ability to take medication, handle personal finances, to prepare meals, and to use the telephone.[3] Not only do the scales vary, but policies interpret the measures in different ways. Some policies require the inability to perform 2 ADL's, while others require the inability to perform 3.

The best way to address this problem is through the development of standard disability-trigger measures that would apply to all policies. This simplification measure would benefit consumers both at the stage when they are shopping for a policy, and at the stage when they need to file a claim. When shopping for a policy, they could be assured that "nursing home coverage" in policy A meant the same thing as "nursing home coverage" in policy B. An independent third party could consider all claims, or there could be an automatic right of appeal to an independent party to review the claim. Now, victims of unfair denial of their claim on their own and typically have to file a lawsuit to pursue their appeal. This is not something that can easily be done when one is incapacitated either at home or in a nursing home.

In preparation for this hearing, I collected a few samples of long-term care policies, and would like to share with you some examples of where policy terms do not protect consumers adequately or are difficult to understand. These are examples of some of the provisions that are out there in the marketplace.

Policy A includes an "Optional Automatic Benefit Increase" provision of "5% of the original amount each year" with the increase ending at age 85, just as policyholders' risk of using benefits increases. This option is not available to applicants who are age 80 or older. This is an example of the use of a simple, not compound, inflation rate. And the inflation benefit is optional, not part of the basic package.

Policy B offers a Home Health Care benefit that appears to look pretty good at first look:

> $35 for each covered visit by a nurse (RN or LPN) or qualified therapist;
> $25 for each covered visit by a home health aide
> $30 for each covered adult day care visit.

However, the fine print in the outline of coverage limits this benefit severely. It requires (among other things) that "your Physician who orders your Plan of Treatment must certify that you

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[3]See **Long-Term Care Insurance -- A Professional's Guide to Selecting Policies**, United Seniors Health Cooperative, February 1991, page 28-29.

would require an inpatient stay in a nursing home if the Home Health Care were not provided." Most people, I believe, assume that home health care benefits could be provided in situations that are less severe than those actually requiring placement in a nursing home.

Another concern about Policy B is the level of the benefit for nursing home care: $50 per day. While a good feature of this policy is that the benefit is automatically increased at a compound rate of 5 percent per year (at no extra cost), it is important to note that $50 covers about 41% of the present cost of a nursing home day in Washington D.C.

Policy C has an "automatic benefit increase option" based on a 5 percent simple increase, not a compounded adjustment. Like policy B, its home health care benefit is limited by the requirement "without such plan, hospital, licensed nursing care facility or other institutional confinement would otherwise be required." This policy could further limit home health care requirements through its definition of "home health care plan" which includes the following:

> "A "**home health care plan**" must include, at least : (1) part-time or intermittent nursing services rendered by, or under the supervision of, a licensed registered nurse (R.N.); (2) part-time or intermittent home health aide services; **and**, [emphasis added] (3) rehabilitative physical, speech, respiratory or occupational therapy rendered by a licensed therapist."

I am sure that many people who may need home health care would not be in need of the type of therapy required in this definition. In fact, it is likely that many policyholders who would meet this requirement would qualify for Medicare benefits.

Policy D provides an interesting variation on inflation coverage. The front page advises "Please note there are two page nines, one for each inflation protection feature." One of the page nines shows a rather typical, though limited, simple inflation adjustment option that increases the benefit by 5% of the initial amount for a period of 20 years. The other page nine describes an inflation index that baffles me. It reads as follows

-- Each increase will be calculated as follows:
  -- Divide:
    the monthly CPI for the period ending three months prior to the Option Date.
  -- By:
    the monthly CPI for the period ending three months prior to the last Option Date. For the first Option Date calculation, the "last Option Date" refers to the Date of Issue.
  -- Multiply the result in the above calculation by the Maximum Daily Benefit in effect at the time of calculation.
  -- Subtract the Maximum Daily Benefit that is in effect. The result is the amount of the increase in the Maximum Daily Benefit.

If this formula gives pause to somebody like me--with an undergraduate degree in math and economics and a highly quantitative graduate degree--then it certainly raises questions about the ability of other people to make an informed decision.

Perhaps as important as what was in these policies is what is not in them. None of the policies I reviewed had any provision for providing any benefits to policyholders who drop their policy. This is a very serious omission. And this small selection of policies can only begin to give you the idea of the extent of variation and confusion that faces the purchaser in this market.

Thank you for providing Consumers Union with this opportunity to comment on issues in the long-term care market. We look forward to working with you as you consider what steps that the Congress should take to address its many problems.

Chairman STARK. Thank you.
Dr. Wallack.

STATEMENT OF STANLEY S. WALLACK, PH.D., DIRECTOR, BIGEL INSTITUTE FOR HEALTH POLICY, HELLER SCHOOL, BRANDEIS UNIVERSITY, AND CHAIRMAN AND CHIEF EXECUTIVE OFFICER, LIFEPLANS, INC., WALTHAM, MASS.

Mr. WALLACK. Thank you, Mr. Chairman. I appreciate the opportunity to return to the committee and discuss long-term care insurance. The last time I talked to you, I talked a bit longer than the 5 minutes. I will try to keep my comments as brief as possible.

Chairman STARK. Go right ahead. We will give you a chance during the inquiries.

Mr. WALLACK. I come at this issue a little differently than other panel members. I have been involved in research on long-term care for a number of years and also have business experience with a company called LifePlans which I founded—to develop long-term care policies with insurance companies and implement them. So I really have looked at this from two sides.

From both vantage points I have come to the conclusion that the Government should play a more active role in establishing guidelines for companies. And I think that what we need to focus on is the goals that the Government is trying to achieve. And I think that is more than just consumer protection. It seems to me from my work and from others that the Government needs to play a very active role in developing this market.

There is a great deal of potential out there. We can argue and Josh and I can argue about the potential of the private market, but there is a lot more potential than we are actually seeing in fact occur. But without the Government playing an active role, perhaps just getting rid of the lemons out there, the market cannot develop. Also, people are ignorant. People are scared.

The Government needs to play a role in developing this marketplace. Developing the marketplace means encouraging choices for consumers. Too much consumer protection on the other hand can stifle the market and limit choice. Therefore, as the Government goes forward and develops an appropriate policy, it must balance these twin goals; the twin goals of consumer protection and the other goal of growth with the appropriate kind of consumer choice. That is a tough challenge.

But I think we have to really try to keep those two things separate, consumer choice and consumer protection. Consumer choice really must reflect the fact that the market needs to meet very different preferences. Individuals want very different things. Their preferences are different. Some people want home care. Some people want nursing home care. Some people have families that are going to take care of them, and they do not want insurance at all.

There is a great deal of differences out there on how people want to protect themselves for their long-term care expenses in the future, given their assets some will want to buy annuities, others insurance. The market for long-term care has got to be looked at in

the total context of an individual, the individual's family and their resources. Therefore you do need choice in the market.

I think we need to consider a minimum benefit package with an awful lot of choice beyond that. Now my two colleagues here on the panel today have picked out the issue of inflation. Inflation being one of those things they would mandate as a consumer protection element.

I feel very differently about inflation. I think in fact if I look at most people 70 years old, which is the marketplace today, and we do survey them and ask them what do they want, they are worried about needing protection today. They are not worried about 10 years from now or 5 years from now. And their preference is to pay the dollars for a higher benefit, not for a higher benefit in the future.

Inflation protection, as Josh said, costs an awful lot of money. In my testimony on page 5, I describe in fact what a 5 percent compounded rate of inflation adjustor would cost. For a 70 year old, it would raise the price of the policy by 56 percent. Now there are other options for that individual as I said before; putting money in a savings account, buying a higher level of benefits.

I find it rather interesting that in other level funded policies like life insurance and disability, we have not mandated inflation protection. Certainly, we should do it for life insurance if we are going to do it for long-term care and certainly we should think about it for disability. Why is long-term care so different?

It seems to me this is really a consumer choice issue and not a consumer protection issue. Whereas I think consumer choice deals with different levels of benefits that people have very different preferences for, consume protection says that whatever somebody buys, make sure they get it; make sure the adequate standards are there; make sure the policy is priced right and make sure those insurance companies are going to be around in 30 years to pay the benefits.

I think the issues of consumer protection are very broad and they encompass an awful lot of things. They encompass the standards, including benefits, of the policy. They encompass the business norms and the practices of the insurance company. They look at the adequacy of pricing and they look at the insurers themselves.

If you look at the problems in the long-term care industry in a global sense, I think there are really two major reasons why the regulations of consumer protection have not kept up in this field and have not been adequate. One is that to a large extent the policy and regulators came at this from a health perspective, not a long-term care perspective.

In long-term care, we should be talking about disabled individuals, for cognitive reasons and physical reasons, needing care. However, many of these policies, in fact, come at this field from a health perspective. And I think that has caused a number of initial problems. As we learn more about this field, we are in fact embracing the view of disability and, therefore, looking at these policies in terms of long-term care needs.

The other thing that is very troublesome is the reactive nature of the regulator, rather than being proactive. One can predict certain

problems are going to occur and we need to build, in fact, these principles into the policy.

Whereas a lot of standards have been changed and we have improved things with regards to, for example, Alzheimer's coverage and NAIC has improved things, there are two problems that are coming down the road in benefits that clearly are going to happen because, in fact, many policies are still using medical necessity, still using ill-defined measures, for who gets benefits. The other problem mentioned, Mr. Chairman, is post-claims underwriting.

If we are talking about disability, we do not have a good tracking between illness and disability. Thus, allowing companies to come in after someone has bought a policy and deny them for some illness reasons leads to some real problems. But, if we take the perspective that we have got a disability product, we can start to enforce certain things. I feel one other concern must be highlighted. This committee and others in the Congress have started to deal with it, the financial adequacy of insurers that are engaged in this market and are marketing their policies.

We need to have standards out there with regard to reserve requirements and with regard to surpluses that are necessary. We want these insurance companies to be strong and vital 30 and 40 years from now. We need to have standards on their financial viability and enforce them.

Mr. McGrath asked a question when he was here a few minutes ago and it is one of the problems I really feel is probably the most important one as you start to look at this field. It is not the standards, although I think there is need for some discussion here about different standards. We seem to have an idea what those standards should be.

The real problem out there as I see it is putting the standards in place and then monitoring them, having the adequate reporting, having the right kind of monitoring and then having the enforcement of them. Clearly, there are inadequate standards out there and you heard a little bit from GAO, but that is a major issue.

So no matter whether you put this responsibility back on the States or on the Federal Government, you have to appropriately monitor them and enforce them. To add more and more requirements to the standards and then not be able to enforce them just seems to me a waste of energy and in fact leads to more and more standards and more and more regulation because in fact we do not know how to enforce them.

An example of that is lapse rates. I have included in my testimony some indepth discussion. I think people are running to make regulatory policy when they do not know what the problem is. We do not understand the lapse rate problem. People price their policies with lapses. If the lapses are too high, is that really a problem for consumer protection or is it the fact that with a new product people are turning to better products that are being made available. People are purchasing them.

Are insurance companies ripping off because of lapse rates? Well it all depends what they are doing with their pricing. A higher than expected lapse rate should result in price decreases. That is what insurers should do. That is what regulators should enforce.

Those that stay with the policy should get the benefit left behind by lapses. The question is, are they?

We need to look at the issue of lapse rates get appropriate reporting and then develop the appropriate kind of regulatory response to that. I think the nonforfeiture alternative, by the way, is one I think is very interesting because I can see nonforfeiture as Josh mentioned it as one way of dealing with the lapse problem, because you build value in for people—if they lapse, they will get, in fact, something out of it.

I do not see it as a consumer protection issue as much as a consumer choice issue. I personally would want nonforfeiture at my age, it would, however, cost me 50, 60, 70 percent more if it had nonforfeiture, because I do not know what is going to happen in 40 years. It is something I would do but I know people who are my age, who are knowledgeable, in the insurance world end who will not do that. They do not want to pay 50 percent more for that feature. It is a consumer choice issue rather than a protection issue.

And it is a consumer choice issue because if we monitor and regulate this industry appropriately, we will take care of some of the lapse issues with regard to appropriate pricing. I think in closing and I apologize for having talked more than 5 minutes, that it is very important as you move forward to include those twin goals of consumer protection and consumer choice.

Just to do things under-the banner of consumer protection, you really are putting into being the choices that you think people want; often they do not. One of the ways of balancing the two, and the one way the Congress in the past has balanced the two, is to put into effect tax legislation like Mr. Gradison. This legislation has some of the appropriate requirements and the appropriate standards that you would want for long-term care insurance.

By putting things in a tax bill you are saying we want to encourage the growth of this industry to some extent; we want to do it appropriately. The last comment I would make and it is one that I feel again that we have got to address if the private sector is to help solve the social problem. The Government doesn't have the money to solve the problem alone. The Government needs to encourage the private market. I propose at the end of my testimony a program similar to one in the early 1970s dealing with the development of HMOs.

When the Congress decided they wanted to change the health care system of this country, they put together the HMO Act of 1973—I was involved in some of that legislation. HMOs were not a household name at that point. The Congress, though, said we want to encourage HMOs; we want to create the credibility of HMOs and it created this notion of qualified plans with standards which also, in fact, had a growth objective to it.

Chairman STARK. You have an eastern bias. You never came to California to see Kaiser or you would not make that statement. They started in 1940. Do you remember.

Mr. WALLACK. I know that.

Chairman STARK. OK.

Mr. WALLACK. But in 1970, we had 29 plans in this country, 29 HMOs in this country. The Federal Government made them credible. Without the Federal Government coming in, the business com-

munity and others looked, but we all had some questions about California. We worried about what was going on in California.

But once Washington said let's look to California and said OK, HMOs, made sense, it had a significant impact by doing that, by qualifying HMOs, with the appropriate standards and by putting the incentives in there of dual choice so every employer had to offer it, Government made a new industry and Government did something which I think has fundamentally changed health care in this country.

It was a very positive approach. Congress said they wanted to control it. It was not done through just regulation. It was done in the context of changing things in a very positive way. I think Congress needs to steer the long-term care industry in the same way. Congress needs to guide it and it can do it in a very positive way rather than a regulatory fashion which is just going to cause more concerns out there.

Thank you.

[The prepared statement follows:]

TESTIMONY OF STANLEY S. WALLACK, PH.D., DIRECTOR
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I appreciate the opportunity to come before the committee today and to discuss the performance of the private long-term care insurance industry and the appropriate role for the public sector in regulating and guiding this evolving industry.

Through my past research endeavors at the Bigel Institute of Health Policy at Brandeis University and my business experience at LifePlans working with insurance companies to design and implement private long-term care policies, I have developed a strong belief that the government should play a more active role in establishing guidelines for companies.

One important role which the government has for all products and markets is consumer protection. However, an equally important role for the Federal government in the long-term care market is to devise strategies that will both define the long-term care market and help foster its development. It is critical that we recognize the impact that consumer protection policies will have on the potential of the private sector to significantly assist in solving the social problem of inadequate risk pooling for long-term care.

The rules established by government must encompass the social goals of consumer protection and encourage the development of the private market to provide fair and attractive plans. Developing the private market means encouraging choices for consumers. Consumer protection, on the other hand, can stifle the market and limit choice. By adopting policies that strike a balance between the dual objectives of consumer protection and consumer choice, I believe the government can stimulate market development.

It is difficult, but the government needs to make a very concerted effort, to distinguish consumer protection and what is perceived to be the most desirable plans or delivery systems. Too often regulation is adopted under the banner of consumer protection when its real objective is to impose the plan that policy makers believe to be in the best interests of consumers. I, for example, support comprehensive benefits for long-term care plans with continuing, personal care management. Yet, many consumers select a nursing home only plan because it is the most cost effective way to secure the financial protection they seek.

The desirable plan -- or what policy makers believe individuals need -- is likely to be less than what individuals demand and, more importantly, goes well beyond consumer protection.

There are two issues I would like to briefly discuss today. First, I would like to attempt to distinguish consumer protection from consumer choice and consumer information. Secondly, I would like to discuss the different ways that consumer protection features are incorporated into the regulatory system, pointing out the importance that industry monitoring has in accomplishing effective regulation. Good regulations need to be implementable and enforceable.

Separating Consumer Protection from Consumer Information and Choice

The long-term care insurance market today is primarily retired individuals, over 90 percent of today's policies cover individuals over 65. Whereas a significant percentage of this population are at risk of needing long-

term care and can afford a policy, only a very small percentage are buying policies. I believe roughly 40 percent of today's elderly could afford a meaningful long-term care policy, but only about 4 percent have a policy. The reasons for the gap between affordability and demand are undoubtedly many and complex.

One problem in today's long-term care market is ignorance of the at-risk populations about their exposure. Another is the belief among many elderly that government programs, primarily Medicare, will pay for their future services. With so much public discussion about long-term care, it is alarming that so many of elderly still believe Medicare will cover their long-term care costs.

Long-term care education today usually occurs "at the kitchen table" between the sales agent and the older individual. There is clearly a need for the government to provide consumer education and to help individuals decide whether or not they should purchase a private policy given the availability of Medicaid and their income/assets.

Even more importantly, many individuals find insurance rules and policies formidable and, therefore, are suspicious of insurance plans. Individuals also may not want to consider the consequences of needing services. Thus, left alone and without guidance many consumers are likely to be underinsured. We see this in all forms of insurance. Often, governments have established tax incentives, requirements or mandates to increase or assure the purchase of insurance. Of course, we are familiar with the fact that risk averse individuals tend to over insure and purchase duplicating policies.

Given the complexity of insurance, I believe the older population would welcome the government informing them about the need and adequacy of private insurance polices in meeting their long-term care needs.

Consumer Choice

An adequate long-term care insurance policy must provide benefits when one needs personal assistance because of a physical or mental disability. However, individuals are likely to want different benefits -- services and dollar levels -- depending on age, sex, ethnicity, and marital status and income status. For example, as one ages, home care and care management appears to gain in importance. Some people want and can afford lifetime benefits, other want inflation protection. The private market has moved rapidly to meet these diverse demands over the past few years.

In short, individuals are demanding different types and levels of benefits, and insurers are providing them. Perhaps, just as importantly many individuals have and expect extended families to care for them. These individuals will not purchase a plan.

Mandating high and comprehensive benefit levels and features like inflation protection will have serious implications on the size of the private market and limit consumer choice.

For example, requiring inflation protection of some amount, say 5 percent compounded, will raise prices significantly.

Table 1

Impact of Inflation on Premiums

Product: A three year NH benefit, 90 day deductible, pays $100 per day in daily benefits with 5% compounded benefit.

	ANNUAL PREMIUMS		
Age	Without Inflation	With Inflation	% Increase
50	$ 230	$ 706	> 200%
60	$ 396	$ 712	80%
70	$1080	$1685	56%
80	$2400	$3240	35%

Table 1 describes the impact on premiums of a three year nursing home policy. The price for a 70 year old will increase by over 50 percent. Paying 50 percent more for inflation protection might be better spent in purchasing a higher dollar benefit. Many people prefer larger benefits, not in the future, but today.

Thus, mandating higher benefit levels or inflation protection could well force individuals to invest resources in a non-optimal manner.

It is interesting that no legislation exists imposing such a requirement on other pre-funded insurance products such as life insurance or disability. It is, however, an option, as it should be for long-term care insurance.

The purchase of long-term care insurance should not be viewed in isolation, but should be viewed as one of many steps taken by individuals to protect their assets, ensure a standard of living and guarantee access to care. An individual might opt to purchase a limited nursing home policy, preferring to invest in other savings instruments. It is neither appropriate nor desirable for the government to impinge on an individual's right to decide how to invest his resources.

Consumer Protection

The primary focus of consumer protection should be on assuring policy holders that they receive the value for which they have contracted and for which they are paying premiums. Whereas consumer choice deals with different value levels, consumer protection deals with the protection of the value purchased, whatever the level selected. Further, consumer protection should deal with the operational norms of insurance companies, the assumptions underlying premiums and the solvency of the insurer. When the method selected for consumer protection raises the value level above the minimum required to satisfy being a long-term care insurance plan, a trade off between consumer choice and consumer protection results. Given the objective of increasing financial protection and consumer protection, we need to target such features to closer scrutiny.

Establishing Consumer Protection Policies in Long-Term Care

Let me now turn to the second issue, how to incorporate consumer protection features. If we take as our goal of consumer protection making sure that what is purchased as a long-term care policy is actually delivered, we have the basis for evaluating the performance of the plan. The first step in this continuum is whether the consumer purchased what they thought they did. Many consumer protection complaints in long-term care are directed at the sales process and how they were ill-informed or pressured by the agent. Such complaints probably take up a good deal of the regulators time. By viewing sales force behavior as a responsibility of the insurance company and making the insurance company responsible for monitoring and reporting, the public may be better served by allowing the regulator to focus on more important areas.

Let me move on to an area where I have more experience and expertise, the adequacy of the long-term care insurance plan to cover needed services.

Basic Plan Requirements

Regulators have over the past few years, achieved a much better handle on the purpose or goal of long-term care insurance and consequently incorporated these features into requirements. Some of the lessons could have been avoided by understanding at the outset what long-term care is, when it is needed and where it is delivered.

Though the need for long-term care is a result of a medical condition, one often becomes disabled over a longer period of time as a result of a complex set of conditions. An understanding of what long-term care is should have, at the outset, established certain minimum standards for policies covering long-term care. For example, exclusion of coverage for Alzheimer and non-inclusion of custodial care facilities as a qualified provider are obvious examples of minimum standards that could have been adopted at the outset. Over time the evolution of the market and the NAIC regulations have lead to the establishment of certain minimum standards for long-term care insurance products. However, there is still more work to be done in this area.

There is a need to establish uniform standards for evaluating whether the premiums charged are appropriate. Along with setting these standards, the regulators should ensure that the experience study submitted by insurance companies are in a format that will enable them to determine whether the minimum standards are being met by of the companies.

Two administrative practices of insurers -- inappropriately borrowed from health care -- need to be modified if consumers are to be assured they will receive the benefits for which they contracted: post claims underwriting and medical necessity triggers for benefits.

By allowing insurers to post claim underwrite, they will be able to make a medical argument that a specific medical condition, e.g. diabetes led to the onset of a problem -- major fall and broken legs. I feel once someone has been accepted by an insurer, benefits must be paid in all instances except fraud.

I am equally concerned about long-term care benefits being triggered by medical necessity. Only a small percentage of the long-stay nursing home patients need skilled care. The reason for long-term care services is disability. We have objective measures of disabilities and these are highly preferable to the ill-defined concept of medical necessity. The trigger for benefits must be based on disability.

The minimum standards that we should require of all policies relate to making sure that the contracted benefits will be forthcoming when the need arises. I have explicitly avoided placing the extent or duration of benefits under consumer protection. While it is clear that a meaningful long-term care policy has to include a minimum level of services, -- say 365 or 730 days of nursing home days -- to pass muster as a long-term care policy, I believe benefits are predominantly a consumer choice issue as opposed to a consumer protection issue.

Insurance Company Financial Criteria

Plan design is an important element of consumer protection. One area of regulatory oversight that has received more attention in recent years and one I strongly support is the regulation of the financial condition of insurance companies entering this field. Often consumers will be paying premiums for 10, 20 or 40 years before benefits will be forthcoming. Thus, there is strong need, particularly in the formative years of this industry, that all writers have the financial wherewithal and ongoing financial management practices to pay benefits.

The regulation of participating insurers is perhaps even more important in this area than life and casualty because this market is comprised of older, individual purchasers of policies. While regulations are in place to assure that reserves and necessary surplus capital are available, I would hope that regulators will develop specific, uniform rules on minimum required surplus and reserving standards. If appropriate rules were established and enforced, the end result will probably be a withdrawal of many smaller, poorly capitalized companies. This would be a good result because significant policy volume is one way of avoiding loss due to chance.

Moreover, my review of many of the major writers appears to demonstrate significant performance variance -- a direct result of their underwriting practices. This points on the regulators need to monitor performances on an ongoing basis.

Monitoring and Enforcement of Regulation

The NAIC has been moving quickly to adopt new standards to incorporate in the model act. Progress in the adoption by states has occurred reasonably rapidly, but national consistency must still be achieved. I am less troubled by the rate of adoption by states than with the monitoring, interpretation and enforcement of standards and procedures. Without adequate monitoring and enforcement, the regulatory response of policy makers is to adopt more regulations and standards.

The enforcement of standards requires that reporting by insurers be done for this line of business separately. Adequate information on premiums, expenses, claims, lapses etc. would go a long way to assess the adequacy of current regulations. Having detailed data will help the regulators operate proactively rather than reactively.

Alternative Paths of Regulating Long-Term Care

Once a problem is identified, the next question becomes what is the appropriate regulatory response. The regulatory approach selected depends on the likely impact of these alternatives, their feasibility, administrative ease and equally importantly the governments attitude as to how this market should unfold.

As an example of the path that regulation could take and how consumer choice and consumer protection are impacted, I would like to use the issue of lapse rates in long-term care insurance plans. Currently, lapse rates experienced by companies appear to be higher than those they have built into premiums. Higher than assumed lapse rates could result in the concerned company making larger profits if premiums are not voluntarily reduced or forced down by regulators.

High lapse rates may or may not indicate the existence of a consumer protection problem. The first question is what should be the expected lapse rates. In an evolving market, higher lapses could be the expected result with consumers switching to newer and better products as they become available. However, lapses could also be because of "churning of consumers".

The cause as well as the impact of lapses should determine the regulatory response. Thus we first need to learn why high lapses occur. If we find that it is a consumer protection problem, then the regulatory alternatives for dealing with the lapse issue are:

1) requiring as design feature of all long-term care policies a non-forfeiture provision,

2) closely monitoring the experience of insurance companies to identify those with high lapses and to adjust their premiums accordingly, or

3) restricting the insurance companies in the field to those that are very unlikely to manipulate lapse rates and/or adopt other poor insurance practices.

If consumer protection were the only objective and no value given to consumers' varying desires or market growth, then the response of insurance commissioners might be to make non-forfeiture a required feature. Since this in effect would eliminate any lapse rate adjustments on premiums, rates would rise. This may not be the preferred alternative. If policy makers are interested in fostering the growth of fair plans, they may not want premiums to increase. Policy makers might then prefer monitoring and enforcement. Monitoring of lapses, loss ratios and price adjustments are only feasible if effective regulatory and reporting mechanisms are in place. If the regulators' response is that they cannot enforce a regulatory policy dealing with high lapses, then I

find it very troublesome and wonder why any financial requirements, potentially including non-forfeiture, are included in regulations.

The policy response to lapses gets even more confusing because non-forfeiture is also an attractive consumer choice feature. I personally find it attractive and would be willing to pay the required 40 or 50 percent more that someone of my age would have to pay for having the freedom to change my evaluation of the need for long-term care insurance in the future. However, those not wanting the option of changing their minds would decide that the higher premium was not worth the benefit. Clearly, to my way of thinking, non-forfeiture should be a consumer choice feature. Requiring it as an option, may be one test of the attitude of insurers to offer fair policies.

The Federal Government Response

In deciding how the Federal government could be involved in setting the course of this evolving industry and in providing consumer protection, I would like this committee and others to think about using "carrots" rather than the regulatory "sticks". One alternative would be to incorporate standards in any tax clarifications as has been proposed recently by Congressman Gradison. Mr. Gradison correctly emphasizes the need for disability benefit triggers and flexibility in plan design and delivery of services.

I would like to advance another idea, which is a more positive as well as a more forceful approach in directing this industry. The approach is best illustrated by past federal legislation, the HMO Act of 1973 and its amendments; which changed the shape of the health delivery system in this country.

The HMO act gave HMO's national credibility and fostered the growth of qualified plans by mandating dual choice. As a result, HMO's became widely available and, consequently were selected by many corporations as their preferred way of providing more cost effective health benefits.

A similar program, federally designated long-term care qualified plans, would go far beyond regulatory standards in establishing the credibility of the fair products that meet societal standards. By incorporating within the qualified plans, the necessary consumer protection features for assuring the program is meeting long-term care needs (policy features), specific financial and reporting standards for insurers providing long-term care and minimum benefit levels, the program would allow the Federal government to properly inform the population, steer the long-term care insurance market and enhance the likelihood that the private sector will play a significant role in financing long-term care expenses.

Thank you once again for this opportunity. I will be glad to answer questions or clarify what I have discussed.

Chairman STARK. Well I want to thank all the witnesses for their testimony. Let me start by trying to get to the left of Mr. Russo. It's become very difficult these days to do this, so let me try to get way ahead of him as quickly as I can. While I do not want to minimize what I see our problems in the present state of the insurance for long-term care, I want to go back to my opening statement. Even if we had the perfect policy and even if we created as good a payout rate as Medicare or Social Security has, if we limited your company to 2 percent overhead—you could not exist that way, but if we did—if we made everything right and gave you the tax credits or deductions you ask for, we still would not be able to deal with 20 percent of the seniors.

There are still 80 percent who would either have to go onto Medicaid because they are so poor. Let's think about this a minute.

The average long-term stay seems to be 6 months or 5 years. I used to say 6 months or 6 years. You go in and in 6 months you get well, die, or you are in because of Alzheimer's. At a 5-year stay you need $180,000 flat. Now that is not talking about the time value of money. Few Americans have $180,000 of life insurance much less cash value that they could spend down.

So you are talking about a savings that is only available to some fairly affluent people. Second, people like us who get paid what most of our constituents think is more than we are worth, will end up with pensions in the neighborhood of $50,000, $60,000, or $70,000 a year. So arguably, we could spend the $36,000 a year for nursing home care and not impoverish our spouse or indeed have to dissipate our assets if we had any. And so we are taken care of.

My point is, because there is really nothing medical in this, there is a change in demographics. We have a lot more old people than we did when I was a kid. We do not have many county farms anymore which we used to have in Wisconsin where if you were poor you went to the poor farm or you went to the Veterans Hospital if you were a veteran. We still run the veterans operation. It is largely a poor folks nursing home situation.

We are talking about an income transfer problem that seems to me really ought to just be lumped into Social Security. We do not know with any actuarial sense who is going to need it. It is a social change. Now that is not going to happen. I hate to suggest where I am coming from. I hate to put Consumers Union out of business on this, but then you could do more on foreign cars.

Ms. SHEARER. That's OK.

Chairman STARK. I want to get that out because we are dealing with a problem that I think is a bad problem. I do not like to see consumers confused or misled. But I do not want to suggest that just by working up this private long-term care consumer product we are going to even touch the surface of what is needed for long-term care.

I am stymied by that, and I do not mean to make this partisan without my colleagues here to speak up on it, but free enterprise is not going to solve this problem. I wish it could but it cannot completely.

Mr. WALLACK. No, I think one of the concerns I have as I look at this issue is how it can unfold in the future. Clearly, if we talk about a group that now needs long-term care, the 80 year olds, we

know they cannot afford it. The same is true for a lot of the 70 year olds. But, if we start talking about future elderly—and whether you do this with social insurance prefunding with workers or individuals do it privately and build up their own reserves, then you are talking about a much bigger percentage of the population.

I believe you have to take a long-time period perspective. Do you want to solve the problem in 1990? The answer to a private solution has got to be no. We have got to say we are willing to buy into solving this problem in the next 20 or 30 years. But having said that, I think there is more potential in the private market than you do. The answer is going to be down the road.

I cannot possibly assure you that everybody is going to want to have private insurance, going to want to buy it; it is voluntary—are they going to find it attractive? A lot of people with money do not want to do it because they have got family that will take care of them.

Chairman STARK. But you are talking to a former life insurance salesman, and it was hard to con somebody out of their hard-earned money particularly when the return in those days was not so good.

Mr. WALLACK. So one of the questions—I guess the bottom line on it is, do we want it for everybody? If I could say to you with some certainty, let's say, that 40 percent of the people will have a policy 20 years from now and 40 percent of the people will have to be on Medicaid, are you willing to buy something less than 100 percent of the population has insurance? Other people would, in fact, spend down, like they do now.

We have got Medicaid. If we did not have Medicaid, that would be another issue—well——

Chairman STARK. But it is.

Mr. WALLACK. I mean, the question really is do you have to have it for everybody? Because if that is the issue then there is only one way to get there.

Chairman STARK. You do have to have it for everybody.

Mr. WALLACK. If that is it, you want the Government to do it.

Chairman STARK. We have to. Sooner or later, health insurance has to be for everybody. Right now, we have 60 million people who cannot afford health insurance.

Mr. WALLACK. Then the question is why do this for long-term care and not a whole host of other social problems? That is what you are going to deal with.

Ms. SHEARER. As you know, we do not believe the private market can come close to solving this problem, and we share your feeling for this. But there is one point I just have to respond to. As a tax subcommittee, we urge you not to take a tax break type of approach. What that would do is it would take money from all income ranges, including the poor, and it will funnel it to the rich. And we just can't accept that. Especially I am concerned that Congress might think they are solving the long-term care problem by enacting a tax change, and it will not solve the problem except for perhaps 5 percent of the population.

Chairman STARK. Let me get back to some technical things now that Mr. Russo has been kind enough to let me try to get to the left of him.

Isn't it true that most insurance companies carry their investment book of reserves against policies like this in portfolios that are designed to compensate for inflation? No longer do insurance companies, because they don't have flat rate. They are used to investing in flexible rates Is that a fair statement?

Mr. WALLACK. It is all over the place. I think the regulators should be able to tell you some of these things about the reserves and how they are allocating their capital. The ones that I am familiar with do very different things. Some are very conservative. Long-term Government bonds, really in very safe securities. Others, of course, have tried to be—not in the risk business, not in the insurance business—but in the financial management business. They may become more aggressive or try to make their money off their holdings.

There is very different behavior out there, and I clearly feel we have got to make sure the companies can pay off their obligations. A major issue is about the surplus of the companies and the reserving policies. I don't think we do appropriate regulation of the companies that are involved here. There are 150 companies in there, and some are writing a small number of policies. Some are unbelievably undercapitalized to be in this field, and I think that is the kind of an issue we need to take on and I think the one the Congress has identified more broadly.

Chairman STARK. Has anybody suggested, as a way to help the industry get started, that we start some kind of risk pool at the Federal level? We would probably never get rid of it if we started it. But until such time as the company has built enough reserve and experience to go it alone?

Mr. WIENER. I am not aware of any. There has been some discussion about pooling data. But this kind of data is typically very proprietary, and it is not something people are eager to share.

Mr. WALLACK. Can I make a comment, Mr. Stark?

Chairman STARK. Sure.

Mr. WALLACK. If you don't mind.

Chairman STARK. Not at all.

Mr. WALLACK. A lot of the performance, the varied performance is a result of these early claims experiences which are all over the place and results from the underwriting practice of who is brought into the plan. If you took a normal population, you could predict with some certainty, I think, what happens. But a lot of the variation that is found is a result of who they enroll up front. And you are finding an awful first year or two not because they didn't predict well 10 years down the road but because of who they took in day one. There is tremendous variations in underwriting practices, some of this goes back to the idea that they can play with this down the road.

I think you can look at these kinds of issues, and make certain that companies do not play with past claims underwriting.

Chairman STARK. Gail, can you account for any of the major swings in cost for an identical or similar policy strictly on commissions? Did anybody find that? Are there vast differences in the cost dependent on how the policies are marketed?

Ms. SHEARER. I don't know the answer to that question.

Chairman STARK. Mr. Russo.

Mr. RUSSO. Thank you, Mr. Chairman.

I find your discussion very interesting on consumer protection versus consumer choice. The one thing that is important in order to protect consumers and in order to give them choice, is to make sure they know what they are getting.

Mr. WALLACK. Absolutely.

Mr. RUSSO. And if someone were to tell you that you were to get a 5-percent increase in your benefit over a 20-year period, and this is how you have to calculate:

> You divide a monthly CPI for the period ending 3 months prior to the option date by the monthly CPI for the period ending 3 months prior to the last option date, where the first option date calculation and the last option date refers to the date of issue, you multiply the result of the above calculation by the maximum daily benefit in effect at the time of the calculation, you subtract the maximum daily benefit that is in effect, and the result is the amount of the increase in the maximum daily benefit.

How do they know what they're getting? How is that choice? I don't know what the hell I just read. [Laughter.]

Mr. WALLACK. Yes, I agree.

Mr. RUSSO. It looks like my Federal tax question when I took the bar exam. Just put a number down and get out of there.

Mr. WALLACK. My question to you, Mr. Russo—and I know your philosophy. You said it before, and about the Federal Government funding this industry. But as I look at this, there is a clear need for education in this field. That is a major responsibility, always has been of the Government. Where is the Government on this educational role? It should be informing people. It should be telling them about what they really need and what kind of policies. It seems to me that is a very appropriate role.

The Government has talked about doing this through Medicare. It should be doing things like that. Education can't be done at the kitchen table by sales agents. People get biased information from the agent that is selling it. That is a very appropriate role, and it is one that, again, right or wrong, in the way the Government would encourage this industry to grow appropriately.

Mr. WIENER. If I could make a comment on the inflation issue, since Stan raised it and you raised it in your example. I have to very, very strongly disagree with Stan on the issue of inflation adjustments. It makes absolutely no sense whatsoever to have the highest indemnity coverage be in the initial years of your insurance coverage after you have been medically underwritten, and have your lowest coverage be somewhere down the road when you are more likely, by a factor exponentially higher, of using long-term care.

I think what happens is that people don't understand what 6 or 7 percent annual rate of inflation will do to that indemnity benefit. It seems to me that adjusting the benefit on a compound basis is absolutely critical to having a policy that doesn't provide a nonillusory benefit.

Mr. WALLACK. Josh, but if you ask people with that choice—all I am saying, Josh, go out there and give people a choice. People who are currently insuring, Josh, are 70 years of age. That is where the market is. Give them a choice of what they want. Lay it out. People insure when they think they are going to have a need for

that benefit. Lay it out to them. Would you rather get a 50 percent higher benefit or buy an inflation rider? They are going to buy the higher benefit.

The real question is what they would do with their money. They would buy the higher benefit. Lay it on them. That is to the ones that have the education. A caveat to this is that, they understand it, but I think they do. I have done some of this in talking to older individuals. Which would you rather have? Would you rather, in fact, buy inflation protection or have a higher benefit for the same dollar amount? They want a higher benefit level.

Mr. WIENER. Just the way you have described that, of course, they would want a higher benefit.

Mr. WALLACK. Of course. You are paying more money——

Mr. WIENER. But that is not what you are getting. What you are getting is a benefit that is a third the amount 20 years down the road.

Mr. WALLACK. People buying it are buying it for the next few years.

Ms. SHEARER. Can I just make a point?

Mr. RUSSO. Sure.

Ms. SHEARER. Inflation is the easy problem. Nonforfeiture is the hard one. If you think inflation is complicated, you should see the way different nonforfeiture benefits could be calculated, not that they are offered now. The important thing with nonforfeiture is that these figures can be easily manipulated by companies. Consumer choice is not the question here. Consumers are not going to understand the complexities of reduced paid up versus all these different types of indexing. There are other important points with nonforfeiture. If there is a good nonforfeiture benefit and it is standard, it changes incentives for companies to price these policies right in the first place. So it has an effect on the lapse situation, but it also has a positive effect on the pricing as well.

Mr. RUSSO. I really think it is unfortunate that the private sector can't do it. Frankly, I would prefer them to do it. I came to Government being very much a private sector advocate, and after 17 years here, I am beginning to realize that you just can't survive with the private sector alone?

Mr. WALLACK. But they do. We are looking at long-term care. It is a new industry, and there is some question of who is playing and this industry is shaken out. How has the insurance industry done in other fields? How have they dealt with this exact same issue? Well, with disability, they built in sort of, you know, fixed rates. They basically guaranteed a rate on disability insurance. The market has done that. With life insurance they have built up policies that have variable benefits. The market has moved in most other fields.

Now, the real question is: How do we educate people, I think—with the Government—we need to get the market developed? This is a tough market because you don't have younger people in it, you don't have employers in it. The Government needs, I think, to play a more active role. But it doesn't mean that the industry won't react. It reacts to provide those kinds of benefits in other insurance products.

Mr. RUSSO. Many people I know have a friend who is in the insurance business, and they rely on them. If you sit down with him and you go through your policy, he'll tell you what is in it. You pretty much rely on him. In most cases that they don't have that kind of a relationship, and so they really believe whatever they are told. Whether it is justified or not, they will believe it. And they are at so much risk that when you see abuses like this, you pause to say, well, wait a minute, why are all these boilerplate exemptions put in this policy if it wasn't for the fact that they really don't want to have to pay for it. They would like to make money, the almighty dollar profit. So as much as I would rather not have Government involved, it seems to me you can't avoid having the Government looking at it and being involved in setting some standards and making sure that there are no misrepresentations.

But it seems to me a simple approach would be a comprehensive approach to national health care, and then you will solve this problem. You don't have to worry about all these different eligibility requirements and whether there are inflation rates and forfeiture rates. People will just have it. I think ultimately before the turn of the century that will probably happen in America because everything else on the way to it will have failed. That is just my view of it all.

Chairman STARK. While we give Mr. Gradison a chance to defend his good name, I just want to ask Gail: You mentioned the problems of nonforfeiture. Is this so much different and more complex than life insurance? In other words, let me see if I can phrase this differently. In life insurance you have got a bundle of dollars that is set aside for the reserve in the policy. And it is just a matter of, upon cancellation, giving it back in one form or another.

Is it that simple in long-term care? Is there just a pool of reserves? And then the question is: Is the technical problems you raise, do you give it in reduced benefits or do you give it—let me ask you this: Is cash for cash a pretty simple calculation?

Ms. SHEARER. It is relatively simple, but it has several drawbacks. It is much more expensive in terms of the impact on the premiums because it doesn't continue to spread the risk, the long-term care risk. And it is for that reason that most people who have looked at this prefer something like a reduced paid-up benefit, which would be something—if you have a $50-a-day benefit initially and you cancel it after, say, 18 years, it might be $30 or $40 a day. And that type of benefit does not have as great an impact on the premium.

So the basic principle is the same as in life insurance, but the calculations and the options are a little bit more complicated.

Chairman STARK. So it is more in the options and in the benefit designs.

Ms. SHEARER. That is right.

Chairman STARK. OK. Well, then, I am going to ask each of you, if you would, to send us really whatever technical, either outline or details that you would suggest in a regulatory bill or in the design of disclosure, because I suspect we are going to try and draft some legislation. This is all pretty new. So you could be very helpful if you would give us some specifications, it would be helpful. I am not sure it will see the light of day, but we might take a stab at it.

Mr. Gradison.

Mr. GRADISON. Mr. Chairman, I apologize for being late. I will be living in the budget world through the end of next week, and then I will return to something far more important, which is the work of this subcommittee.

I don't have any questions because I haven't had the benefit of hearing the discussion. I just want to tell you where I am coming from on this. I regret enormously to see the issue of long-term care mixed in with the question of health care. I think the long-term care issue is far more a wealth issue than a health issue. While our present benefit programs are not adequate and certainly should be expanded with regard to the adequacy of reimbursement, and the opportunity for home health care should be an option, the poor have some degree of protection.

The main pressure I find for long-term care action at the Federal level is from people who have some savings and they don't want to deplete them. In other words, they save for a rainy day, and when it is raining they want somebody else to hold up the umbrella. Fortunately, private health insurance, whether we do anything about it or not, is going to grow. I hear lots of this debate, and, you know, I can take myself back many years to when health insurance came in for acute care. And I could hear the argument—it wasn't made then, but somebody said:

> This is terrible, only the rich are going to protect themselves for their hospital bills. We shouldn't let that happen. We shouldn't encourage that. Government could do it much more fairly and uniformly.

Baloney. We got a lot of things we need our money for in the health care field before we protect people's savings and their estates. You know, maybe someday we will get around to having adequate resources for that purpose, but the needs in the acute care area in my judgment are far greater.

So I look at this field with, frankly, some bemusement at the efforts that are being made to pooh-pooh the potential for long-term care insurance and to stand in the way of State experiments like the Connecticut proposal. I think that those experiments deserve a chance. They may prove to be inadequate, but I don't think that we ought to be standing in the way of innovative approaches for dealing with this issue.

Now, what I am hearing in my district—and I have heard it often enough that I think I should mention it here—is that one of the big problems in the current situation is diversion of assets by well-to-do people who have chronic diseases that they are reasonably sure are going to require permanent nursing home stays. I will stress the word "permanent." I have even run into a term I never even heard of before called a Medicaid trust. I am told there are even books on how to do this, although I can't tell you the sources, but that is what some of the nursing home people tell me.

We have some abuses out there that need to be corrected, and I think there are—why? Because the resources available in a resource-scarce world should be used for the people with the least ability to meet their own needs. And that is not what a lot of this attention is given to. I am not trying to give a speech, but I just want you to know. If that sounds defensive, I am sorry, but there is

another point of view on this, and I just want you to know where I am coming from.

I thank you for your patience.

Mr. WIENER. Would you entertain a comment on that?

Mr. GRADISON. Of course, Josh.

Mr. WIENER. I would like to make two. One is I think long-term care reform has to be broader than asset protection. All of the major bills that have been proposed for public long-term care insurance programs would substantially expand home care as well as provide financing for nursing home care. But I think the question I would ask you is, "What is the fundamental difference between acute care and long-term care?" With the Medicare program, virtually nobody says that as a routine matter of course we should let people impoverish themselves down to $2,000 in protected assets. In fact, you and the chairman spent a good bit of your political capital trying to improve that situation so people did not face those financial problems for acute care.

Mr. GRADISON. Sorry you remember.

Mr. WIENER. The other point is that long-term care and health care for the uninsured must be joined together because neither by themselves has enough political support to get themselves passed. All the public opinion polls show that people are more willing to pay taxes for long-term care than they are for health care for the uninsured. Health care for the uninsured desperately needs the association with long-term care to tap into that willingness to pay taxes, and long-term care needs health care for the uninsured to take the very strong edge off the generational equity issues. So I guess I would suggest a completely different strategy, and one that in fact tried to bring those two issues together, not tried to separate them.

Mr. GRADISON. As you know—I said this when we were together on a program back in Cincinnati a few days ago—I have tremendous respect for the ground-breaking work which you and Alice Rivlin have done on this subject. I would answer you very briefly on your points in this way:

First of all, I honestly don't believe if we were starting again we would write the Medicare program the way we did. In other words, I think saying, "OK, here is how we did it in 1965 and that should be a model for what we do in other programs today," does not fit what we have learned since 1965. Now, that is just my opinion.

I thought it was interesting in the discussion on the Budget Committee the other day that we, in effect, endorsed in principle the idea that the income of a Medicare beneficiary should be taken into account in determination of their payment of a part B premium. The decision whether to do anything is up to this committee and the Energy and Commerce Committee. The initial intention of the committee when we began the debate in the Budget Committee wasn't to come out with that point of view, but we did in the end, unanimously. And I think that is kind of indicative of the changing thinking about this issue.

With regard to your argument, which may be correct, that you have to join them together to get either one, I think there is a risk in that. I think that because of the large amount of revenues that would have to be raised to do both together, the chances are that

long-term care, would get financed first, that the other would be waiting, and we would, 5 or 10 years after that, be saying:

> Gee, the Pepper Commission recommended it. We pumped $40 billion a year into long-term care. Why are hospitals closing? Why are people lacking health insurance?

I think it would be at that point that we discovered, while there certainly are health aspects to long-term care, that is not principally what it is all about.

So, believe me, I respect your viewpoint. I only say this to indicate that, while we may disagree, I have an answer at least.

Chairman STARK. I want to thank the panel again, and I look forward to your suggestions of what we might do to improve the policies for the few number of people who can afford them and participate in them. Thanks a lot.

Chairman STARK. Our second panel includes two witnesses from the insurance industry: Mary Nell Lehnhard is vice president of the Blue Cross and Blue Shield Association, a former member of the Ways and Means Committee staff, I might add. Paul Rapo is here representing the Health Insurance Association of America. He is the legal director of the Employee Benefits Division of Aetna Life & Casualty, and is a member of HIAAs Long-Term Care Task Force.

Would you like to proceed, Mary Nell? Mr. Rapo, would you like to introduce your colleague?

Mr. RAPO. Mr. Chairman, I am Paul Rapo, and I have today with me Susan Van Gelder, associate director of public policy and research at HIAA.

Chairman STARK. Thank you very much.

Mary Nell.

STATEMENT OF MARY NELL LEHNHARD, VICE PRESIDENT, OFFICE OF GOVERNMENT RELATIONS, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Ms. LEHNHARD. Mr. Chairman, Mr. Gradison, I would like to spend my time commenting on the current long-term care insurance market and specifically the products that we have on the market. I would also like to discuss our belief that this rapidly growing and changing market should be left at this point to the regulation of the States.

The long-term care insurance market has grown fairly rapidly in a short time. Twenty-six of our plans now have products on the market, compared to only one plan in 1986, and we expect several more products on the market in the near future. I would note, however, that we have been very cautious in how rapidly we move because of many of the things you have heard today with respect to the lack of actuarial experience in this market.

We expect that the number of policies will grow more rapidly as employers begin to offer policies for their employees. In 1987, there were only two employers nationwide that offered coverage, and this number is up to about 180 now. We are now seeing mid-size employers begin to offer this as a benefit.

As Blue Cross and Blue Shield plans have gained experience in this market, they have done a much better job of meeting the

needs of consumers. For example, in addition to providing all levels of nursing home care, our products cover a wide variety of home and community-based services that includes home health visits, adult day care, respite care and, in many cases, homemaker services, durable medical equipment and transportation. None of our policies require hospitalization as a condition for receiving benefits.

Almost all of our policies base eligibility on an individual not being able to perform two out of five ADLs, and some of our plans are using cognitive impairment as an eligibility criteria for diseases such as Alzheimer's. This allows someone who can function physically to be able to qualify for benefits, but not mentally.

All of our plans also provide the services of a case manager to work with the client, their family, and the physician. These managers develop a plan of treatment, locate appropriate services in the community, and then monitor that treatment on an ongoing basis.

Almost all Blue Cross and Blue Shield policies also are designed to protect against inflation by offering as an option, features such as annual benefit increases and/or periodic opportunities to increase benefit levels. Policies generally are available to persons between the age of 40 and 79, and premiums vary with age at initial purchase level and the benefit options selected and should remain stable over the life of the policy. None of our plans that we know of have requested an increase in the premiums. All of our products are guaranteed renewable, meaning that they can't be canceled because of use.

We believe that the NAIC has acted quickly and effectively to develop standards for this market. We are concerned that Federal standards that go beyond the NAIC current models could make products unaffordable, hamper growth of the market, and, importantly, stifle development.

According to NAIC, 48 States have adopted a version of the Model Act and/or regulations. We recognize that action has been somewhat slower on these yearly amendments to the original Model Act, but we think that States will continue to adopt the amendments.

As we see the market mature and the States catch up in adopting NAIC amendments, we feel that all the States will eventually have a very comprehensive regulation of these products in place.

We also believe that the NAIC has done a good job of balancing the need for consumer protection against the need to have affordable products on the market. This was discussed at length in the last panel.

For example, while we agree that benefits such as inflation protection and nonforfeiture protection should be offered by insurers, requiring insurers to include all of these benefits in every policy will make products unaffordable for many. Requiring a policy to include inflation protection compounded at 5 percent over 20 years, we estimate would increase the premium for a 50-year-old by 100 percent and 71 percent for a 65-year-old. A nonforfeiture provision would increase the premium by 57 percent for a 50-year-old. We strongly believe that consumers should have the option to decide, depending heavily on where they are at their point in life and what they anticipate their immediate needs are whether to pay this additional premium for these types of benefits.

In conclusion, we stress the need for continued regulatory flexibility to support the development of long-term care insurance products, and we think that NAIC has been responsive to this need while still addressing consumers' needs. Given the short timeframe and the newness of the product, we believe the States are moving to adopt regulatory programs.

That concludes my statement.

[The prepared statement follows:]

TESTIMONY OF MAY NELL LEHNHARD
BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and Members of the Subcommittee, I am Mary Nell Lehnhard, Vice President of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans nationwide.

My testimony will focus on three areas:

- The current and future role of private long term care insurance;
- Our support for establishing effective state regulation of long term care insurance products; and,
- Our recommendations for federal measures to encourage the availability of good-value long term care insurance for those who need it.

The Blue Cross and Blue Shield Association believes that there is a very serious need for long term care coverage in this country. We believe that private long term care insurance can and should play a major role in financing long term care for those who need it without requiring them to face economic catastrophe.

We recognize the importance of assuring that consumers are getting good-value insurance coverage and support aggressive state action to enforce state established standards for long term care insurance. We believe that states have the flexibility to develop and implement standards that will protect consumers while fostering continued growth of this important insurance market. We do not believe that federal standards are needed at this time.

DEVELOPMENT OF PRIVATE LONG TERM CARE INSURANCE MARKET

The long term care market has come a long way in a very short time. In 1986, there were only 130,000 long term care insurance policies sold compared with the more than 1.85 million policies sold by the end of 1990.

Over the past few years, the number of Blue Cross and Blue Shield Plans marketing long term care insurance has increased dramatically. Twenty-six of our Member Plans are currently marketing these policies compared to only one Plan in 1986. Several more are expected to enter the market in the near future.

Long term care insurance products have changed significantly over this period. Most of the industry's earliest policies were quite restrictive. These policies typically offered nursing home coverage only and required prior hospitalization before individuals could receive benefits. Other types of care, such as home care, were seldom offered.

As the market has evolved, insurers have gained more experience and have developed more flexible long term care insurance policies offering benefits that meet a variety of needs. For example, in addition to care provided in all levels of nursing homes, Blue Cross and Blue Shield long term care products cover a wide variety of home and community-based health services, including home health visits, adult day care, respite care and, in some cases, homemaker services, durable medical equipment and medical transportation. No policies require prior hospitalization as a condition for receiving benefits.

In almost all policies, eligibility for benefits is based upon the inability of an individual to perform 2 out of 5 activities of daily living (eating, dressing, bathing, transferring and toileting). Some Blue Cross and Blue Shield Plans also use cognitive impairment as an eligibility standard. This allows persons suffering organic brain diseases, such as Alzheimer's, who can physically perform the activities of daily living to qualify for benefits.

All of our Plan policies also provide the services of a case manager to work with the client, family and physician to develop a plan of care, locate the appropriate services and help monitor treatment. Other features in some of our policies include the following:

- o Non-forfeiture of benefits. If a policyholder discontinues payment of premiums for any reason after a minimum number of years, the policyholder does not forfeit all coverage but is entitled to reduced benefits.
- o Paid-up options. An individual can pay somewhat higher premiums for a fixed number of years (e.g., 10 years or up to age 65) after which the policy is paid in full and the policyholder is entitled to the full level of benefits.
- o Return of premium. If a policyholder dies before using the benefit, the premiums paid are returned to his or her beneficiary.

Almost all policies are designed to protect against inflation by offering features such as annual benefit increases (i.e., annual percentage increases in fixed payment amounts for covered services), or periodic opportunities to increase benefit levels. A few Blue Cross and Blue Shield Plans offer benefits in their long term care products which base payment on a percentage of the cost of services received rather than a fixed daily "indemnity" benefit. This type of payment structure helps keep pace with health care cost inflation.

Policies generally are available to persons between the ages of 40 and 79. Premiums vary with age at initial purchase and with the benefit options selected and should remain the same over the life of the policy. All of our products are guaranteed renewable, meaning that the policy cannot be cancelled because of a change in health status or use of benefits.

The long term care insurance market will grow even faster as the number of employers offering long term care policies to their employees increases. In 1987, only two employers nationwide offered coverage to their employees. This number grew to over 180 employers by the end of 1990. While most of these are large groups, mid-size employers are beginning to offer coverage as well. In most cases, the employees pay the premium.

There are many advantages to long term care policies sponsored through employer groups. Policyholders are usually younger (average age is 43 years) than those enrolled in individual policies (average age is 72 years) and, as a result, premiums are lower. For example, for the same policy, the annual premium for a 50 year old is $236 while the premium for a 70 year old is $1,468. Also, due to lower administrative and marketing costs, the premiums for group-sponsored products are generally lower than those of individual policies.

Employer group plans also reach a broader range of people. Coverage is usually offered to active employees, spouses, and/or retirees. In some cases, parents and in-laws are offered the opportunity to add coverage through the group. The employer sponsorship also lends credibility to the product through the scrutiny of experienced and knowledgeable benefits managers who select and examine the product for quality and value on the employees' behalf.

LONG TERM CARE INSURANCE STANDARDS

As the long term care insurance market has grown, the National Association of Insurance Commissioners (NAIC) has aggressively moved to develop standards to protect consumers. In 1986, the NAIC adopted a Model Act establishing standards for the sale and quality of long term care products. A comprehensive set of Model Regulations was adopted in 1987. Changes in these models have been made each year including: a prohibition on prior hospitalization requirements; a requirement that questions about an applicant's health be clear and unambiguous; and a prohibition of certain restrictions on access to home health care benefits.

In December of 1990, the NAIC approved additional consumer protection and policy requirements including:

- Requiring agents and insurers to make a reasonable effort to ensure the policy is appropriate.
- Prohibiting high pressure sales tactics and "twisting" (purposely misrepresenting a comparison of policies to induce a sale or replacement).
- Imposing fines on insurers and agents (for violating state regulations or marketing practices) of up to three times the amount of commission paid or up to $10,000, whichever is greater.
- Requiring insurers to offer an inflation protection option no less favorable than annual benefit increases compounded at a rate of at least 5 percent.

We believe that the NAIC has acted quickly and effectively to update its long term care insurance standards while allowing sufficient flexibility for the market to grow and develop. These standards are developed with extensive input from consumer advocates and the insurance industry. We are concerned that an effort to establish federal standards that go beyond the NAIC standards could make products unaffordable, hamper growth of the market and stifle development of innovative benefits.

According to the NAIC, 48 states have adopted a version of the Model Act and/or the Model Regulations or some related regulation of long term care insurance. We recognize that state action on the frequent amendments to the Model Act and Regulations has been slower, but we believe that the states will continue to add the amendments as they are developed. As the long term care insurance market matures and there is less need for annual changes to the NAIC Models, the states will become current and will have adopted comprehensive long term care standards.

We understand your concern that consumers purchase good value long term care insurance policies. And we agree that benefits such as inflation protection and non-forfeiture protection should be offered by insurers. However, requiring all policies to include all of these benefits only exacerbates one of the concerns identified by this subcommittee, i.e., the policies become too expensive for the majority of elderly persons.

We have attached a table derived from a report prepared for the NAIC by an actuarial advisory committee which illustrates the effect on premiums when inflation protection and non-forfeiture protection are included in a policy. Requiring a policy to include inflation protection compounded at 5 percent over 20 years increases the premium for a 50-year-old individual by 100 percent and by 71 percent for a 65-year old. A nonforfeiture provision would increase the premium by 57 percent for a 50 year old person. We believe that consumers should have the option to decide whether to pay the additional premium for including these types of benefits in the package they purchase.

Beyond the cost concerns, there are situations where a consumer might not want some of these protections. For example, a 70-year-old man purchasing a long term care insurance policy might reasonably conclude that the purchase of a higher daily benefit would be more advantageous than increasing the benefit through inflation protection. Another person, with limited finances, might prefer a policy without inflation protection to having no coverage at all.

Some members of Congress have suggested parallels between the federal standards established last year for Medicare Supplemental insurance and possible federal standards for long term care insurance. We would like to stress that long term care insurance is very different from Medigap insurance. Thus, standards for one should not be applied to the other. Medigap insurance provides supplemental coverage for a federal health care program and has been marketed for 26 years. Long term care insurance is not tied to a federal program and has only recently been marketed by a substantial number of insurers.

- The gaps in Medicare coverage are basically the same for all beneficiaries and are focused on acute episodes of care. Long term care insurance provides coverage for a significant portion of chronic illness which can last for many years.

- People buy Medigap to fill a specific need. People buy long term care insurance for many different reasons including access to long term care services or protecting assets from spenddown to Medicaid. Therefore, a wider range of products is needed.

- Medigap is rated on an annual basis with claims filed throughout the year. Long term care policies are rated over the life of the policy and claims often are not filed for 20 years after the initial purchase.

- While most people are familiar with the need for Medigap policies, many do not realize that they are not covered for long term care.

- The long term care insurance sale is more lengthy and complex than the sale of a Medigap policy. Agents are often required to spend hours educating consumers about long term care policies and will often come back several times before selling a policy.

In short, applying Medigap type regulations to long term care insurance is inappropriate because the products are vastly different.

When we testified before this subcommittee two years ago, only 26 states had taken any action on the NAIC models. Now 48 states have acted to regulate long term care insurance. Given this movement by the states to regulate the sale of long term care insurance policies and the rapid changes in the market, we do not feel that federal standards are needed.

If, however, Congress still believes that the establishment of a federal voluntary certification program for long term care insurance policies is necessary to encourage further state efforts in this area, we would support such action for long term care products provided that the voluntary federal certification program incorporates the standards developed by the NAIC. We could not support the development of new federal standards.

Enactment of a federal voluntary certification program that relies on the current NAIC Model Act and Regulations would assure that appropriate federal efforts to protect consumers who buy long term care insurance are based on the expertise of the nation's insurance commissioners, without duplicating or supplanting state regulatory authorities.

Finally, we believe that states must adequately enforce existing regulations. Adoption of the NAIC Model Act and Regulations will not provide the necessary protection unless they are enforced.

FEDERAL ASSISTANCE FOR LONG TERM CARE PRODUCTS

Long term care products have matured significantly since the original products were first introduced. Second and third generation products have been developed to respond to consumer preferences for guaranteed renewability, home health benefits, and no prior hospitalization options. In spite of the encouraging nature of new long term care insurance products, several issues remain to be addressed which would encourage faster growth in the market.

Establish tax incentives. Tax incentives would encourage the development and sale of private long term care policies to those who could afford coverage. Specifically, we suggest:

- Tax Exclusion for Employer-Provided Long Term Care Benefits. We recommend that long term care insurance be given the same tax-favored status granted to group health benefits. Specifically, benefits paid out and employer contributions for long term care insurance would be excluded from an employee's income. We believe that employers should be allowed to deduct contributions to a long term care plan as a current expense and to offer long term care coverage as part of a cafeteria plan.

- Individual Deductions. We recommend that individuals be permitted to deduct qualified long term care expenses and premiums using the limited medical expense deduction allowed under Section 213 of the Internal Revenue Code. This section allows individuals to deduct medical expenses in excess of 7.5 percent of their adjusted gross income.

- Calculation of Long Term Care Insurance Reserves. Finally, we recommend that insurers be allowed to establish long term care reserves on a tax-favored basis after the insurance has been in force for one year. Allowing reserve build-up under the one-year method would help insurers keep premiums as low as possible.

We commend Congressman Gradison for introducing legislation yesterday that incoporates tax incentives for long term care insurance. This approach is consistent with the changes we have recommended to provide a stable environment for expansion of long term care coverage.

Expand public long term care education activities. We strongly support a government role in clarifying for individuals the nature, extent and risks of potential long term care expenses. Many older people continue to be under the impression that Medicare provides coverage for long term care. While this perception is slowly changing, public misunderstanding on this issue is clearly a major obstacle to the expansion of needed long term care coverage.

We also would support government efforts to educate the public regarding eligibility criteria and benefits covered under the Medicaid program. This would give those individuals not eligible for government long term care benefits or who do not wish to spenddown to Medicaid the opportunity to plan, if possible, for their long term care needs in advance -- before private coverage is unattainable.

CONCLUSION

In conclusion, the Blue Cross and Blue Shield Association stresses the need for continued regulatory flexibility at all levels of government to support the development of the long term care insurance market. We believe that the NAIC has been responsive to the long term care insurance market while still addressing consumers' needs. We also believe that the industry has been responsive to consumer demands.

Nearly every state has acted to regulate the sale of long term care insurance over the last few years. However, if the federal government feels that a voluntary certification program for long term care policies is necessary for those states that do not adopt existing model language, we strongly recommend that the adopted federal insurance standards incorporate only those standards developed by the NAIC, not revisions to them or completely new standards.

We want to thank the subcommittee for this opportunity to present our views. We will be pleased to work with you as you continue to look at the issue of long term care.

ADDED PREMIUM COSTS OF INFLATION PROTECTION AND NONFORFEITURE PROVISIONS

TABLE 1
First-Year Annual Premium by
Inflation Protection Case

Age	No Inflation Protection	Inflation Protection (simple)*	Inflation Protection (compound) **
35	$ 72	$ 96 (+33%)	$ 108 (+ 50%)
50	$ 168	$ 276 (+64%)	$ 336 (+100%)
65	$1,080	$1,632 (+51%)	$1,848 (+ 71%)
75	$2,880	$3,816 (+33%)	$4,068 (+ 41%)

From NAIC report, November 1990, p.10.
* simple 5% inflation over 20 years
** compounded 5% inflation over 20 years

TABLE 2
First-Year Annual Premium with and
without Nonforfeiture Provision

Age	Without nonforfeiture	With nonforfeiture
35	$ 72/yr	$ 108 (+50%)
50	$ 168	$ 264 (+57%)
65	$1,080	$1,236 (+14%)

From NAIC report, November 1990, p.50.

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Chairman STARK. Proceed, Paul.

STATEMENT OF PAUL S. RAPO, ASSOCIATE LEGAL DIRECTOR, AETNA LIFE INSURANCE CO., ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY SUSAN VAN GELDER, ASSOCIATE DIRECTOR, DEPARTMENT OF POLICY DEVELOPMENT AND RESEARCH

Mr. RAPO. Good morning, Mr. Chairman and Congressman Gradison. My name, again, is Paul Rapo. I am associate legal director of Aetna Life Insurance Co., and I am pleased to testify today on behalf of the Health Insurance Association of America, which represents 300 private health insurance companies providing health insurance to 95 million Americans. Again, with me today is Susan Van Gelder, associate director of policy and research at HIAA.

HIAA fully recognizes the need for strong consumer protection laws and their full enforcement. The market will not survive without them. However, HIAA does not support the creation of Federal standards regulating long-term care insurance products for several reasons. Let me go into detail as to these reasons.

First, long-term care insurance and its market is growing rapidly, offering consumers both meaningful and affordable protection. Prior to 1985, only 24 companies sold long-term care insurance. Today over 140 companies are selling long-term care insurance. As of mid-1990, over 1.65 million policies had been sold.

More importantly, the products have undergone tremendous changes in benefit structures. This has been in response to consumer demand, market, and regulatory pressures. An analysis by HIAA of products being offered in early 1991 by 12 companies representing 75 percent of all policies sold found the following: All but one offered both nursing home and home health care coverage; none contained a 3-day prior hospitalization requirement; all offered at least 4 years of coverage; all offered inflation protection; all plans were guaranteed renewable; all offered a 30-day free look; all provided Alzheimer's coverage.

Although the market is quite young, it is clear that good products are widely available.

In terms of affordable products, HIAA believes that long-term care insurance can offer affordable long-term care protection for millions of Americans. In the employer market where the average age of a long-term care buyer has been 43, the average yearly premium is $200 for a plan offering an $80-a-day nursing home benefits and 5 years' nursing home coverage. For the Aetna plan that my wife and I are covered under, we pay a total monthly premium of $23.

In the individual market, yearly premiums for a plan providing an $80-a-day nursing home benefit with 4 years of coverage and a 20-day deductible period average $505 at age 50, $1,055 at age 65.

Analysis by LifePlans, Inc., suggests that between 50 and 70 percent of those in the workforce, as well as a high proportion of nonworking spouses, could potentially be covered by a long-term care insurance policy. Clarification of long-term care insurance as health insurance in the Federal Tax Code could push this figure

toward the upper bound estimate. For example, Congressman Gradison is expected to introduce such a tax clarification proposal this week, and we look forward to working with you on this very critical issue.

Among the current elderly population, LifePlans estimates that over 40 percent could afford and qualify for private long-term care insurance.

Let me now address the second point in terms of State regulation. To date, 43 States have passed the NAIC legislation, model legislation or model regulation. Additionally, six States have some other form of——

Chairman STARK. Excuse me. Would you say that one again?

Mr. RAPO. Forty-three States have adopted some version——

Chairman STARK. Some version. I think you left that out when you just spoke.

Mr. RAPO. OK.

Chairman STARK. They have not adopted the complete version. There are widely differing versions of that. Correct?

Mr. RAPO. That is right, Mr. Chairman, and I believe my written testimony has those critical words in there.

Additionally, six States have some other form of long-term care insurance regulation. My testimony says only two jurisdictions, Pennsylvania and District of Columbia, and if I believe my colleague here—and I do—we are down to one jurisdiction without regulation of long-term care insurance; namely, the District of Columbia.

[The following was subsequently received:]

HIAA

Health Insurance Association of America

April 30, 1991

Robert J. Leonard
Chief Counsel
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Leonard:

Please find enclosed the corrected transcript for Paul S. Rapo, witness for the Health Insurance Association of America, at the Subcommittee on Health Hearing on Private Long-Term Care Insurance, held on April 11, 1991.

For the record, the HIAA would like to clarify that Pennsylvania has not adopted long-term care legislation, but rather has legislation introduced and pending enactment. This leaves Pennsylvania and the District of Columbia without any long-term care laws at this time.

There was some confusion during the question and answer session as a result of erroneous information from HIAA staff. We apologize for any confusion, and would appreciate it if this letter were included in the record.

Sincerely,

Anne Marie Walsh

Anne Marie Walsh
Assistant Washington Counsel

cc: Paul S. Rapo
Susan Van Gelder

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

Mr. RAPO. HIAA remains committed to working actively to have all States adopt the models and update their existing laws. Although the NAIC Model Act and regulation are important, they comprise only one of several State initiatives at regulating long-term care insurance. Long-term care insurance is also subject to the NAIC Unfair Trade Practices Model Act, the NAIC Uniform Individual Accident and Sickness Policy Provision Law, the NAIC rule governing advertisements, and the NAIC Life and Health Policy Language Simplification Act. Clearly, a number of State laws exist to protect consumers from long-term care abuses, making it one of the most regulated insurance products. Without strong enforcement, however, these laws are meaningless.

Third, long-term care insurance is not medigap. Although long-term care insurance and medigap insurance are primarily purchased by elderly individuals, it is important to note that they are very different products. The Federal Government's role in regulating policies to supplement a Federal entitlement program such as Medicare is different than that with long-term care, where no appreciable Government overlap exists with private sector policies. As a result, there is no standard set of gaps to fill with this product.

Finally, education is the key to consumer protection. The importance of an educated industry and public cannot be overstated. The insurance industry is acutely aware that it stands to lose the most if they sell products that are inadequate, underpriced, or employ deceptive marketing practices. HIAA strongly believes that the biggest payoff in consumer protection will come from an educated consumer and an educated industry.

To this end, HIAA is working actively to achieve this objective in a number of constructive ways. This includes the distribution of a free consumer's guide to long-term care insurance and the operation of a toll-free hotline number.

In conclusion, Mr. Chairman, HIAA does not believe Federal standards for long-term care insurance are appropriate. Thank you for this opportunity to express the views of HIAA. I would be pleased to answer any questions that you or members of the committee may have.

[The prepared statement follows:]

TESTIMONY OF PAUL S. RAPO
HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning Mr. Chairman and Members of the Subcommittee. My name is Paul Rapo, and I am Associate Legal Director of the Aetna Life Insurance Company. I am pleased to testify today on behalf of the Health Insurance Association of America (HIAA), which represents 300 private health insurance companies providing health insurance for 95 million Americans. With me today is Susan Van Gelder, Associate Director, Department of Policy Development and Research at HIAA.

At HIAA, I Chair a committee which has spent the last several years working with the National Association of Insurance Commissioners (NAIC), to develop and improve a model state statute for long-term care insurance products. I am also the most recent Chair of the NAIC advisory committee, comprised of industry, consumer, and provider organizations, which assists the NAIC on the same subject.

HIAA welcomes the opportunity to testify today on the status of the private long-term care insurance market and the consideration of proposals to establish federal consumer protection standards for such products.

HIAA fully recognizes the need for strong consumer protection laws and their full enforcement. The market will not survive without them. However, HIAA does not support the creation of federal standards regulating long-term care insurance products for several reasons. Let me discuss these reasons in more detail.

1. THE LONG-TERM CARE INSURANCE MARKET IS GROWING RAPIDLY, OFFERING CONSUMERS MEANINGFUL AND AFFORDABLE PROTECTION.

Market Growth

Prior to 1985, only 24 companies sold a long-term care insurance policy. Today, over 140 companies are selling long-term care insurance. Many diverse products are being offered -- consumers may buy coverage on an individual basis; through their employer; as part of their membership in a continuing care retirement community; or as part of their life insurance policy.

The number of people who have purchased long-term care insurance has more than doubled since 1987. As of mid-1990, over 1.65 million policies had been sold. Our research suggests that over 250,000 more policies were sold in the second half of 1990.

Although the market is still dominated by products sold individually to an older population, newer vehicles, such as employer-sponsored arrangements and coverage under life insurance plans, have grown rapidly since their recent introduction. The number of people covered under employer plans, including retirees and parents of employees, quadrupled over an 18-month period, from 20,000 at the end of 1988 to 80,000 in mid-1990.

Aetna Life Insurance Company, for example currently only issues coverage to employer groups as part of an employee welfare benefit plan. Since writing the nation's first employer sponsored long-term care plan for the retirees of the State of Alaska in 1987, we now provide coverage to 21 employers. These include Procter & Gamble, Chrysler, General Foods, Bristol-Myers Squibb and the State plans of Ohio and South Carolina.

Other types of products are also developing, for example, between 1987 and mid-1990, the number of people purchasing coverage as part of a life insurance contract increased from about 1,000 to more than 14,000. Clearly this market is young and just beginning to demonstrate its potential, especially among the nonelderly population.

Meaningful Protection

More importantly, the products themselves have undergone tremendous changes in benefit features and design in response to consumer demand and market and regulatory pressures. An analysis

of products being offered in early 1991 by 12 companies representing 75 percent of all policies sold found:

- All but one offered both nursing home and home health care coverage. In addition, over half (7) offered an adult day care benefit.
- All but one based eligibility for nursing home care on physician certification of need. One insurer sold a policy which determined eligibility using limitations in activities of daily living.
- All offered at least 4 or more years of nursing home coverage. Over half (7) offered an unlimited lifetime nursing home benefit.
- All but one plan was sold to persons up to age 84 or older.
- All offered an inflation protection feature. In most cases, the inflation feature increased the initial daily benefit 5 percent over a period of years. Three insurers, however, also provided a compounded inflation protection benefit.
- All plans were guaranteed renewable.
- All offered consumers a 30-day free-look period during which time they could return their policy for any reason and receive a premium refund.

In addition, all the plans covered policyholders who develop Alzheimer's disease and waived premiums after the policyholder was confined to a nursing home. Typically, the daily nursing home benefit amounts available ranged from $40 to $120 a day and were usually half that amount for home health care. Consumers were usually offered a choice of deductible periods which ranged from 0 or 20 days to 90 or 100 days.

Although the market is quite young, it is clear that good products are widely available across the country. Furthermore, newer products, although a smaller percentage of the market, tend to offer newer benefits. For example, most newer policies condition benefit eligibility upon becoming disabled in a number of activities of daily living rather than physician certification of need. Some policies offer case management services. A few policies determine eligibility for noninstitutional care based on disability alone; they do not require that the disabled individual receive formal home care services.

The Aetna group plans offer employers the following features:

- 5 years or unlimited lifetime coverage;
- No medical underwriting of active employees;
- No prior hospitalization requirements;
- No level of care distinctions (covers skilled, intermediate and custodial);
- Portability of coverage if employee or plan terminates,
- Inflation protection -- (5 percent compounded);
- Nonforfeiture offering of extended term or reduced paid-up;
- Return of premium contribution if death occurs prior to age 65;
- Benefit eligibility based upon a loss of functional capacity. Receipt of professional services is not required;

- o 0 day premium waiver;
- o Employer solicitation.

Company Experience

In 1989, HIAA conducted a survey of 27 member companies selling long-term care insurance to determine what their market experience had been to date. Although the data should be considered preliminary given most companies' recent introduction to the market, the following information was reported:

- o Most companies required an attending physician statement for all applications or under certain conditions such age or the presence of a specific health condition. Additionally, 15 companies conducted follow-up phone interviews with every applicant. Across companies representing 40 percent of the market, an average of 76 percent of all applicants were approved for coverage.
- o All companies using an agent force provided a copy of the policy's outline of coverage at point of sale.
- o Across companies representing 40 percent of the market, an average of 10 percent of all policies were returned within the 30-day free-look period for a premium refund and cancellation of the policy.
- o Across companies representing one-third of the market, the average annual lapse rate, including first year, was 16 percent. As a means of comparison, the average lapse rate for ordinary life insurance policies in 1987 was 10 percent, and for life insurance policies in-force less than 2 years, it was 20.5 percent.
- o Although very few companies had enough experience to report claims information, for those companies with at least 25 filed claims, the median percentage of claims approved for payment was 88 percent. The most frequent reasons for denial were failing to meet the preexisting condition requirement, failing to meet the deductible period, and misrepresentation or fraud on the application.
- o Across companies representing one-third of the market, the average first year agent commission rate was 36 percent. The average second year commission rate was 11 percent. After 5 years, the average was 7 percent. Independent agents generally do not receive the entire commission, however, because it is also used to help pay overhead such as office space, management and support staff.

Affordable Products

HIAA believes that long-term care insurance can offer meaningful and affordable long-term care protection for millions of Americans. In the employer market, where the average age of a long-term care buyer has been 43, the average yearly premium is $200 for a plan offering an $80 a day nursing home benefit, 5 years of coverage and providing a 90-day deductible period. For example, under the Aetna plan, my wife and I pay a total monthly premium of $23.

In the individual market, yearly premiums for a plan providing an $80 a day nursing home benefit for 4 years with a 20-day deductible period average $505 at age 50, $1,055 at age 65 and $3,815 at age 79. If an inflation protection benefit is added, average premiums increase to $650 at age 50, $$1,335 at age 65 and $4,510 at age 79. (Premium data are based on those companies representing 75 percent of market.)

LifePlans, Inc., which conducted research based on current pension and health insurance coverage, suggests that between 50

and 70 percent of those in the workforce, as well as a high proportion of nonworking spouses, could potentially be covered by a long-term care insurance policy. Clarification of long-term care insurance as health insurance in the federal tax code could push this figure toward the upper bound estimate. For example, Congressman Gradison is expected to introduce such a tax clarification proposal this week and we look forward to working with him on this critical piece of legislation.

A recent Fortune survey of 500 executives indicates that long-term care is the most likely type of employee health benefit to be added over the next 5 years. It is estimated that clarification of the tax treatment for employer-sponsored plans could increase this market by 35 percent. In addition, such legislation is important for recognizing the unique nature of certain long-term care products -- such as those using life insurance or those that provide benefits based upon a level of disability rather than upon the receipt of formal services.

Among the current elderly population, LifePlans, Inc. estimates that over 40 percent could afford, and qualify for, private long-term care insurance. These estimates are based on a consideration of four factors -- income levels, nonhousing asset levels, age, and disability status. Based on this finding, the LifePlans researchers conclude that a significant gap exists between the demand for private insurance and affordability of private insurance. The market will not develop to its full potential until people are educated to understand the risk and costs of needing long-term care.

2. FEDERAL STANDARDS MAY INHIBIT NEW PRODUCT INNOVATION.

While today's products provide meaningful benefits, we are not at all certain that they represent the ultimate in product design. Given its brief history, we do not know yet where the products will go in terms of what funding mechanisms may be used to pay for them or what benefits such products might finally provide. The employer market and life insurance products, which accelerate death benefits for such needs as long-term care, have only been recently introduced. Other concepts are on the drawing boards. A single set of federal standards could well result in inhibiting such product innovation, just when it is needed most.

3. THE STATES HAVE REACTED RESPONSIBLY IN REGULATING LONG-TERM CARE INSURANCE.

NAIC Long-Term Care Model Act and Regulation

Long-term care insurance is an evolving product. It is critical that the regulatory environment allow for the development of new and different products while protecting consumer interests. HIAA believes, this dual regulatory objective is best met at the state level.

In December 1986, the NAIC first adopted model legislation which successfully balanced the needs of both the industry and consumers. A model regulation was adopted shortly thereafter. Since then, the Model Act and Regulation have been amended several times to better meet consumer needs.

To date, 43 states have passed legislation or adopted regulation based on some version of the Model Act or Regulation. Additionally, six states have implemented some other form of long-term care insurance regulation. (See attached chart.) Only two jurisdictions -- Pennsylvania and the District of Columbia -- have not yet passed legislation or adopted a regulation specifically for long-term care insurance. The product, however, is not unregulated in these jurisdictions, but rather falls under the numerous laws of general applicability for group and individual health insurance. Moreover, in states with specific long-term care insurance laws, long-term care insurance is also subject to all state health insurance laws.

HIAA is encouraged at the speed with which states have acted to govern this new product. As an industry, we understand more than anyone that the potential for consumer abuses must be eliminated if we are to sustain a viable market. Therefore, HIAA remains committed to working actively to have all states adopt the models and update their existing laws.

Although states are moving rapidly in adopting legislation and regulations specific to long-term care, it is certainly true that not all states have adopted the most recent version of the NAIC Model Act and Regulation which was only adopted by the NAIC four months ago. However, it is important to note that companies selling long-term care insurance on a nationwide basis have been voluntarily updating their policies to comply with updated versions of the Model Act and Regulation as they have been amended several times over the last few years. These policies are widely available in states that have not kept pace with the NAIC amendments.

Other Relevant State Laws

Although the NAIC Long-Term Care Insurance Model Act and Regulation are important, they comprise only one of several state regulatory initiatives applicable to long-term care insurance and consumer protection. Specifically long-term care insurance is subject to the NAIC Unfair Trade Practices Model Act, supported by the HIAA and applicable in all the states, which provides consumers with the broadest range of protection against inaccurate product descriptions, fraud, misrepresentation as well as improper denial of benefits. Long-term care insurance is also subject to the NAIC Uniform Individual Accident and Sickness Policy Provision Law, again supported by HIAA and applicable in all states, which specifies a variety of consumer protection provisions regarding such items as the policy form, specific policy provisions and policy applications.

In addition, long-term care insurance may be subject to the NAIC Model Rules Governing Advertisements of Accident and Sickness Insurance, adopted in a majority states (all but 6), which provides guidelines for truthful and accurate disclosure of health insurance advertising as well as the NAIC Life and Health Policy Language Simplification Model Act, adopted in a significant number of states (30), which requires policies to be written in simple language and large print.

These and a number of state laws exist to protect consumers of long-term care insurance, making it one of the most regulated insurance products on the market. Given this vast state regulatory process, structure, and expertise, HIAA strongly believes that the states are better able than the federal government to regulate an evolving product which requires equal consideration of consumer needs and product development. Federal standards would create a burdensome dual state and federal regulatory environment producing inevitable competition between state and federal legislators to "out consumer protect" the other. This could result in a set of standards so costly to the consumer that private long-term care insurance is no longer an option to Medicaid spend-down.

Although state adoption of the Model laws is essential, equally critical is the enforcement of those laws. HIAA strongly supports the adoption and enforcement of all state health insurance laws, not just those pertaining to long-term care, to prohibit illegal or unscrupulous practices. Without strong enforcement, the laws themselves are meaningless.

4. LONG-TERM CARE INSURANCE IS NOT MEDIGAP.

Although long-term care insurance and Medigap insurance are primarily purchased by elderly individuals, it is important to note that they are very different products. Medigap insurance is purchased to fill the gaps not covered by Medicare, the

government sponsored insurance program for acute care for the elderly and disabled. Moreover, the acute care provider network is well established, whereas the long-term care provider network is still evolving. Long-term care insurance is intended for catastrophic long-term nursing home or home health care and is not necessarily appropriate for all elderly.

The federal government's role in regulating policies to supplement a federal entitlement program such as Medicare is different than with long-term care where no appreciable government overlap exists with private sector policies. As a result, there is no standard set of gaps for this product to fill. In addition, because long-term care insurance is still evolving and unlike Medigap policies have no need to be uniform, federal standards could result in severe restrictions in the market's development.

Unlike Medigap, long-term care insurance is being provided increasingly through the employer setting to younger individuals who are able to purchase policies at more affordable prices long before they need the benefits. These sales are not typically solicited through agents but are marketed as part of the employer's overall employee welfare benefit package. The average age of such enrollees is 43.

Additionally, Medigap is written on an expense incurred basis so that it can "coordinate" coverage with other medical plans the insured may have. Coordination is less likely of a problem in long-term care since the coverage is typically written on an indemnity basis that pays a fixed dollar amount -- regardless of other insurance.

Finally, budget considerations make it highly unlikely that a government sponsored program for long-term care will be enacted any time soon. Cost estimates for publicly funded programs have been prohibitively expensive. The Pepper Commission estimated that its long-term care proposal would cost an estimated $46 billion. A front-end approach, similar to the proposal advocated by Senator Kennedy, has been estimated to cost $27 billion annually. A two-year back-end public program introduced by Senator Mitchell during the 100th Congress has been estimated to cost $23.86 billion in 1990. Given such costs, it would seem much better to encourage the purchase of private long-term care insurance today to minimize the number of people who will be candidates for public long-term care financing tomorrow.

HIAA strongly believes that the private sector must share in the cost of paying the nation's long-term care bill. We should not and cannot rely exclusively on government solutions -- especially when many people can afford to protect themselves.

5. EDUCATION IS KEY TO CONSUMER PROTECTION.

The importance of an educated industry and public cannot be overstated. The insurance industry is acutely aware that it stands to lose the most if we sell inadequate products, underprice the product, or employ deceptive marketing techniques. As stated above, we strongly support the adoption and enforcement of all state health insurance laws, not just those pertaining to long-term care insurance, to prohibit illegal or unscrupulous industry practices.

In addition to these actions, however, HIAA strongly believes that the biggest pay-off in consumer education will come from an educated industry and consumer. To this end, HIAA is working actively to achieve this objective.

Insurer Education

On the company side, HIAA is a founder and cosponsor of an annual conference on private long-term care insurance which is planned by eight diverse organizations including the American Association

of Retired Persons, the National Governors Association and the American Association of Homes for the Aging. Now entering its seventh year, the conference brings together industry and public policy makers to address the development of the long-term care insurance market and its role in financing long-term care.

To highlight the need for unique consumer protection requirements in the area of long-term care, the HIAA Board of Directors has adopted a policy paper which recommends guidelines for its member companies in the areas of company, agent, and consumer education; disclosure; marketing practices; and policy benefit provisions. I would be pleased to provide a copy of the paper to you if you are interested.

To help meet the educational needs of persons selling long-term care insurance products, HIAA and the American Association of Homes for the Aging are cosponsoring three national conferences in mid-1991 targeted specifically for agents, financial planners and other persons selling long-term care insurance products. Our objective is to educate this group not only about what constitutes a good long-term care insurance product, but also to educate them about the long-term care population, the service and delivery systems, and the way it is currently financed. It is our intention to use any proceeds from the conferences to help support state insurance senior counseling programs.

HIAA, through a recent survey of its member companies, has also found a strong company commitment to agent education, training, and monitoring. In terms of agent education practices, 21 companies, representing 45 percent of the market, reported the following:

- 86 percent had developed a long-term care specific agent training guide,
- 74 percent had conducted long-term care specific training seminars,
- 42 percent had developed a long-term care newsletter, and
- 28 percent had written an agent underwriting guide.

When asked about specific agent marketing practices which were monitored by companies, a number of activities were noted. Companies monitored policyholder complaints (75 percent), persistency rates (60 percent), loss ratios (60 percent), applicant rejection rates (47 percent), replacement rates (46 percent), and overall profitability (39 percent). In most cases, such monitoring was conducted at the individual writing agent level although in many cases, the branch office/agency was also monitored.

Consumer Education

At the consumer level, HIAA has been active for several years in developing and distributing free copies of our Consumer Guide to Long-Term Care Insurance to three-quarters of a million Americans. We also operate an 800 number telephone hotline service which receives about 2,400 - 3,000 calls a month from consumers asking about health insurance. (The number is 800-942-4242.) Consumer interest in long-term care insurance has been strong and growing representing about 10 percent of all health insurance questions in a given month.

CONCLUDING COMMENTS

In conclusion, Mr. Chairman, HIAA does not believe federal standards for long-term care insurance products are warranted or appropriate. We believe that states are highly sensitive to the issue of long-term care insurance regulation and are responding responsibly. We strongly support state regulation and oversight of all insurance products, including long-term care insurance.

We also believe the market is in its infancy and could suffer irreparable harm if inhibited by standards which are likely to be inappropriate as the market diversifies. Lastly, we believe it is the responsibility of both the private and public sectors to educate the public about their potential long-term care needs. We firmly believe that the key to consumer protection is education.

Thank you for this opportunity to express the views of HIAA. I would be pleased to answer any questions you or members of the Subcommittee might have.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. I would like to ask each of you just one question. Are you convinced, absolutely convinced, without any reservation, that long-term care is an insurable event, or is the jury still out on that?

Mr. RAPO. I look to both sides of me, and I see people looking at me.

We are convinced that it is. There has been a tremendous amount of research, particularly in terms of predicting, for example, nursing home confinement. There have been some studies—and I think Susan can tell you exactly those studies done by the Federal Government and HHS—that activities of daily living is a good predictor, both in the underwriting process and in the claim adjudication process.

Ms. LEHNHARD. Mr. Gradison, I would have to tell you that there is a difference of opinion within the Blue Cross and Blue Shield system. The plans that have products on the market obviously think it is an insurable event, but they have been very cautious about entering this market. Other plans are not so comfortable with the idea of the unknown liabilities and the extended time frame that you carry those liabilities, and they have not entered the market for that reason.

Mr. GRADISON. Thank you.

I don't mind leaving it at that point, Mr. Chairman. I am not sure about this one myself. I think this is a long-term issue from the point of view of the insurers. I appreciate the research that has gone on. I have read some of these studies, and I still think there is clearly some degree of subjectivity with regard to the measurement of the ADLs. I don't know how big a band of disagreement there is about this. I guess what it really comes down to is that I would feel a lot better about a growing national role if I thought we had, to be blunt about it, the political maturity to have a system where we would tailor it to the needs of the individual family, as Britain tends to do. You send an interdisciplinary team in, and examine the needs of the family. You find out how many hours they can help. You know, you do all that, rather than making it in a sense an automatic entitlement.

But my own impression is that we would be unwilling to let that happen. The entitlement mentality is strong and alive in this country in the private and public sectors. To me, it is something we have to fight against. We can't pay for the promises we have already put on the books in the health care system, and we know that. It astonishes me, at a time when we are told the Medicare hospital insurance trust fund is going to go bankrupt in 15 years, that we are talking about anything except how to keep that one going without focusing on how to start something new.

Thank you.

Mr. RAPO. Congressman Gradison, if I may just add a point and a concern that you raised. We at Aetna have been trying for some period of time to work on case management and implement it as part of our claim analysis and part of our services that we provide our insureds. We are presently working with a number of area councils on aging and trying to get national networks of case managers established. That is a difficult process because the provider

network is uneven across the country. But it is a very worthy goal for the private sector to be pursuing now.

Mr. GRADISON. Thank you, Mr. Chairman.

Chairman STARK. I want to congratulate the health insurance industry in their strategy. They have sent perhaps two of the finest representatives they could find. They were smart enough not to send the American Integrity Insurance Co. here to testify because we would have handed them their heads. And I am afraid your testimony in the presence of that gang in the room would not hold water. You are the white hats of the industry and are to be congratulated.

But what you leave out of your testimony is that—NAIC has done a great job. I really think so. If I thought that within 6 months the toughest NAIC proposals would become the law of every State in the land, I would adjourn this hearing now, and we would all go home and not worry. Unfortunately, you and I know that isn't the case. Even the Blues don't think so, although many of the insurance companies have voluntarily adopted what are the NAIC standards. But they haven't all met the highest standards of some of the Blues.

Now, Aetna and Mutual Benefit and Pacific Mutual are quality companies with unimpeachable marketing standards. I'm not talking about them. But how do we deal with the bad apples? In certain States, the legislatures haven't taken the entire NAIC proposal, arguably because they have been lobbied out of it to allow the loopholes to serve the convenience of some companies who do not like the regulation. So for those of you who live by the highest standard and are prohibited competitively from getting a fair share of the market, what can we do to make sure that everybody plays by the same rules. That ought to be an advantage to your Blues, should it not?

Let me put it this way: Is there any advantage to allowing substandard policies to be sold in competition with Blue Cross and Blue Shield?

Ms. LEHNHARD. No. You are absolutely right. It can create a competitive advantage if you are putting in all the bells and whistles in it and it costs you money. When we were here a couple of years ago testifying, I think we were very open to the idea of Federal standards if States didn't move. And we were very explicit about that in our testimony. On balance we feel that the States have moved.

Chairman STARK. Would you be in favor of that now?

Ms. LEHNHARD. We would look again at some time period out, but just the fact that 49 States have either the Model Act, the regulations, something in place——

Chairman STARK. How many have the Model Act in its entirety?

Ms. LEHNHARD. Susan, you probably know.

Chairman STARK. I would guess about 20.

Ms. VAN GELDER. I would have to get that total. Half maybe have the Model Act, based on the Model Act.

Chairman STARK. Twenty-odd have the Model Act in its entirety?

Mr. RAPO. Excuse me, just to add something——

Chairman STARK. I am just guessing.

Mr. RAPO. Just to add further confusion to it for the sake of that, the NAIC made 10 changes in December of 1990. I suspect that those changes have to be implemented. They were all consumer protection amendments primarily supported by the industry, and we have to keep moving in that direction. I believe the standards are in place. Standards don't equate to enforcement, however.

Chairman STARK. I do have the numbers. This is the 1988 requirements. They haven't been changed. Twenty-four States still have no requirements on guaranteed renewal; 17 States don't have standards disallowing Alzheimer's exemptions; 12 States don't prohibit coverage from being conditioned on prior hospitalization; and 11 States still don't prohibit policies from limiting coverage to skilled care. That is 1988. That isn't the new ones that have come in.

Now, still, within those States, Aetna, probably adheres to all of those. I think you do.

Mr. RAPO. Yes.

Chairman STARK. So what we heard earlier is that the companies are signing up for the most part, and the NAICs is doing a good job. It is the State legislators, quite frankly, who are for one reason or another are allowing loopholes to be chewed in the NAIC standards. And I think that is what we are really talking about here. I think there is some agreement about what ought to be done and what are decent marketing practices and the benefits that ought to be made available. I think the Blues agree to that. I think Aetna does also. And, I think the Health Insurance Association does. But there are still some bad apples out there, as it is in every case.

We went through this on medigap. So, hopefully we will be able to work out a solution that will accommodate the 75 or 80 percent of the companies who do the right thing.

This is all we are trying to do. I think you appreciate that we would like to work together and that there are that small group. As I say, unfortunately, they are not at the witness table this morning, or we could have some fun. [Laughter.]

Chairman STARK. You both supported Mr. Gradison's bill to modify the Tax Code. But we also know that if we do that, we are going to reduce Federal revenues, which will bother my colleague, Mr. Gradison, by some unknown amount.

In the past, your industry and in particular, Blue Cross and Blue Shield have argued that Federal dollars should be targeted to pay for the long-term care needs of low-income people. But if we go at it through the tax clarification, you contradict that. You are basically helping richer people who are the only ones, as we have heard testimony today, who really can afford this.

How do you wash that one with the other?

Ms. LEHNHARD. I am not sure that I can respond to the tradeoff of which you do first. We think that we have never presented private long-term care insurance as being able to meet the total needs, even of those who can afford it, because some people just won't buy it. We have expressed tremendous interest in programs like Senator Mitchell where you let the private insurance industry do the up-front for 2 years. We think that does create some incentives to purchase insurance.

Chairman STARK. And then the Government take the long tail?

Ms. LEHNHARD. Yes. We have also supported tax clarification to encourage the purchase, and I am being very specific that the low income will never get into the mainstream of private insurance. We have the same dilemma that everybody else does, that there is not enough dollars to do all of these things. And we have not made choices among those.

Chairman STARK. We could do a very affordable long-term care bill if we took the Mitchell bill. But I am a wild spender, and I think when you get down to the first couple of months it costs $40 billion a year. But if you get out to having private insurance take the first couple of years, we get down to around $12 billion. Is it $12 or $15 billion? I mean, wasn't Mitchell's $25 billion for 2 years?

Mr. GRADISON. Would you yield, Mr. Chairman?

Chairman STARK. If you went to 3 years, it got down to around $20 billion, as opposed to $60 billion which is what I am saying. This is done by just adjusting the front end.

Mr. GRADISON. Would you yield very briefly?

Chairman STARK. Yes.

Mr. GRADISON. My recollection is that the Mitchell bill had a 2-year exclusionary period—the people were on their own—and 30 percent coinsurance thereafter. But it cost about $25 billion, and more to the point, it was considered and was criticized by many people, some of them in this room, I imagine, as being chintzy. And that was $25 billion. I don't know where that is going to come from.

Chairman STARK. Mine would have cost $60 billion and gone to 2 months. But there is the range. It is pretty linear. And I suspect if we went out to 3 years, we would get it down.

Ms. VAN GELDER. Could I comment on the Mitchell bill and the HIAAs proposal?

Chairman STARK. Yes, please.

Ms. VAN GELDER. I will speak for Stan. An analysis that he did indicated fully operating and running, annual costs of the Mitchell bill or a Mitchell-type proposal would be about $26 billion a year. The other critical issue to us, and we do not support the Blues' position on this, is that it does nothing for people who still have no coverage or can't afford private insurance in that 2-year period, they are still subject to spend-down into Medicaid. What it does do is protect assets for very wealthy people who tend to buy the insurance and stay 2 years. So in essence, it is raising tax dollars for estate protection for heirs because those people will not leave the nursing home. It is bad public policy. Whether or not there is a market for the insurance industry is another question, but that is bad public policy.

Our own proposal—and, again, we are all struggling with revenue sources—is to do both: to expand Medicaid but to promote the private market. And we believe together, through tax clarification and through expanded home care benefits and raising the Medicaid asset levels, that this is cheaper than the $43 billion Pepper proposal.

Chairman STARK. Inexorably you fall right into the arms of Stark and Russo and just say let's have universal access and socialize it. Then we don't have to fuss with all this——

Ms. LEHNHARD. We will see about that.

Chairman STARK [continuing]. And swallow the costs and figure out how to pay for it through the Tax Code. But that is going to take us a few more years to get done. [Laughter.]

I don't say this to throw down gauntlets. But, I rather suspect that we will see some legislation on this topic this year. I say that not to suggest that Mr. Gradison and I are going to take off our coats and roll up our catastrophic sleeves again and show what brilliant legislators we are. But there are other committees here on the Hill also taking a look at this, and I suspect that the hounds have the scent of blood from their victory in medigap last year. So I have a hunch we are going to be doing something.

It would be of some help to this committee if you could swallow hard and at least suggest to us, if there were going to be standards, which ones you might find least objectionable and in what format you might like to see them presented.

Ms. LEHNHARD. Mr. Chairman, we never fail to work with you, and we see you are going to do something anyway. We have urged in the past that if you do determine that you need to do something federally, that you do follow the NAIC standards. I think their track record shows that every time a new product comes on the market, that it has considered whether or not it should be required or required as an option. What we are concerned about is going beyond what the NAIC has done and putting in place Federal standards that do inadvertently increase the policy by as much as 50 percent for people who don't need that option because they are 70 years old, 75 years old, and they don't need nonforfeiture, they intend to pay their premiums.

Chairman STARK. If we could do a little corporate gene splicing between NAIC and Consumers Union, I would be willing to just get out of this field altogether right now. But I will appreciate your continued cooperation.

Mr. Gradison.

Mr. GRADISON. Mr. Chairman, one of the charms I thought of what we did last year was the idea of—with regard to medigap—a basic policy and then allowing options to be added to it. Now, one of the problems which has developed all around the country with regard to a basic policy is that we have been allowing mandates from the States for perfectly good things, but they add to the cost of basic acute care health insurance. And we know that these mandates add 15, maybe 25 percent to the cost of the basic policy. We also have reason to suspect that there is a market out there for basic policies. At least States like Virginia are trying to find that out.

So I don't know exactly how you would intend to structure this, but I thought that was a pretty good idea of saying, "OK, this is the absolute minimum basic policy, and then we add to it." But I sense that some of the provisions which you would, for sufficient reason, insist are basic, others would say really should be options and shouldn't be in that basic policy. And I don't know how we resolve that at this stage of the developing industry.

Chairman STARK. I don't think in the benefits I would have any. I think the benefits probably are separable. There are some marketing reasons people might want to bundle them up. But I do think the idea of cash value and noncancelable policies are the sort

of things would apply, whether you had a $10-a-month benefit or a $1,000-a-month benefit. There might also be a certain minimum dollar amount that is needed to make the policy economic; in order to cover the costs of marketing and the administration of it. I don't know whether you could price Alzheimer's separately.

Basically, it would seem to me a basic policy is *x* dollars a month indemnity type if you meet certain standards. I don't think that is in trouble. I think what we are talking about are underwriting policy sales things that would be pretty generic. I would have no objection with you, and I think this is simpler insurance. I don't think there are as many variables in long-term care insurance as there are in medigap. Would you agree with that?

Ms. LEHNHARD. I would agree with that today, but we are seeing the products develop, and we don't know what the benefits are in the next 6 months. We are also concerned about a situation where you might endorse something that the NAIC does in the future. We don't want to see literally legislative authority turned over to the NAIC. So there are lots of different factors here.

Mr. GRADISON. And even on the nonforfeiture issue—I may be missing something entirely—but to me what you are saying is like saying to the life insurance industry you can only sell permanent forms of life insurance, you can't sell term.

Chairman STARK. No, but the nonforfeiture was a regulatory decision by the State regulators years ago for this very same reason. It was not the life insurance companies who designed nonforfeiture values. In the history of life insurance, it was the regulators.

Mr. GRADISON. I understand that history of it. But they continue to permit the issuance of term. I would argue—certainly agree that renewable term makes a lot of sense. They shouldn't have to have a new physical exam. I understand that point. But to say that if you don't pay your premium, you don't get anything back—if you don't pay your rent, you can't stay in the apartment either. I mean, what is wrong with that principle?

Chairman STARK. It just has to do with the reserve value of the policy. There are some very rich reserve policies in which case there is a problem to determine it.

Mr. RAPO. Just a couple points, Mr. Chairman. There are some distinctions here when you start thinking about medigap and standardized policies. This is a developing marketplace, and we have seen tremendous growth, for example, in the employer group market. And quite frankly, we don't know exactly where that market will go. Hopefully, tax clarification will further stimulate it.

But there are other products that could be devised in the employer market. For example, a term product that converts at age 65 to a level premium product, the cost of that—I mean, if I am paying $11 or $12 a month right now on a level premium basis, I would hope that there would be some consideration along those lines that we don't want to inhibit those kinds of products when we even think about standardizing them.

The other point here is the possible dual regulatory framework here of Federal and State standards, and one trying to outdo the other, out-consumer protect the other, and we then develop Cadil-

lac policies that are unaffordable, and we haven't addressed the problem.

Chairman STARK. I think those points are well taken. As I say, that just gets me to renew my invitation for you to further enlighten us in the event that we do go forward. You would be very helpful in that regard. Thanks very much.

Mr. RAPO. Thank you.

Chairman STARK. And now, we're pleased to welcome back Commissioner Earl Pomeroy, who is the past president of the National Association of Insurance Commissioners. I guess he was turned out of office because he lost the medigap fight.

And he's now back in the great State of North Dakota, as commissioner of insurance, full-time, and he has seen fit to appear unaided and unarmed. It is good to have you back.

Would you like to proceed to enlighten us any way you are comfortable.

STATEMENT OF EARL R. POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. POMEROY. Mr. Chairman, thank you, very much.

At this hour, being on the last panel of the hearing, I'm going to shorten my presentation quite dramatically. The written statement, I think, contains a reasonably comprehensive view of this market from the regulatory perspective, and I trust it will be part of the record of this hearing.

Chairman STARK. Without objection, it will be.

Mr. POMEROY. There's little doubt, by our view, that the public desires protection against ruinous costs of long-term care. We think the sale of 1.6 million long-term care policies is testament to the desire of a range of consumers, that believe they ought to be allowed to protect some of their assets against the spend-down levels required by Medicaid before assistance is available for the costs of long-term care.

The regulatory community, on the other hand, hardly sees long-term care insurance as a panacea for the long-term care financing dilemma facing this country. We believe that it can be an appropriate product for estate protection, provided that policies pay when people expect them to; that policies can be sold in a manner that is not inherently abusive or unfair; and third, that policyholders are treated fairly by their insurers.

State regulators, individually and working through their association, the NAIC, have closely tracked this market, and evolved regulatory requirements to meet the above objectives. In the written testimony, on pages 5 and 6, there is a list of a number of quite significant consumer protections now required of these policies.

State implementation of the NAIC standards is reasonably comprehensive. It is not perfect; it is not what I wish it was, but we do believe that it is reasonably comprehensive and responsive to the needs of the insurance consumers of this country.

Part of the reason that a snapshot, as of today's date, may reveal some States not in compliance with the present model is that we have observed a time lag of approximately 2 to 3 years before the

individual States will pull into effect those changes most recently brought into the NAIC model.

Part of the reason I feel that States have lagged somewhat in bringing the most recent NAIC long-term care model changes into effect is that they have been working with the medigap requirements which have changed in each of the last 3 years.

I also believe that if you look at the regulatory protections in place, in the States, you will see that they have responded to those areas within this market that have given the consumers a problem. While they might not have the full complement of protections in those areas where there was abusive conduct occurring, you will see the States responding.

As it also has been noted in prior hearings, most of the market is adhering, we believe, to the NAIC model in order to obtain an ease of national marketing, regardless of whether a State has fewer protections in place.

There are some major problem areas that need to be closely watched within this market. Consumers must be aware that due to the indemnity nature of this policy, the benefit may not be an adequate level, due to the inflation of long-term care costs, or a stay longer than the coverage period purchased.

We are concerned about marketing activities that might over-sell this product—selling people of near Medicaid eligibility fairly expensive long-term care insurance policies regardless of whether they should have estate protection concerns.

Third, we believe that the consumer should be aware that there is no assurance rates will not go up, and sadly in some instances, they have gone up quite dramatically as company experience has required.

We're at a point in evolving the regulatory strictures on this market that has become extremely technically demanding. Some of the more obvious regulatory responses have long since been identified and moved into the NAIC model. The issues now before us are very technically demanding and difficult.

Underscoring the difficulty of our task is that this is a new market, a complex market, and an extremely risky and expensive market. Therefore, an inappropriate regulatory response, we believe, can definitely hurt this market, if not critically damage it.

One aspect of the debate involves requiring a rich, comprehensive benefit, albeit at cost of affordability, and therefore, access of the middle class to this product. The tradeoffs are obvious. At what point does a policy lack a comprehensive character so that it is inherently abusive, or illusory.

On the other hand, at what point do premiums reach the level where you effectively deprive the middle class of access to this product? I have constituents in North Dakota that want to protect family farms, but don't have huge income streams to buy the rich benefit designs.

I have constituents in North Dakota who want to make certain that they have adequate resources, should one or both spouses become institutionalized. These are very difficult questions and have to be considered carefully.

As we move into this stage of the regulatory debate it is clear the question before us this morning, is Federal regulation required to

promote uniformity and to assure a minimum threshold of adequacy of regulatory standards? I don't offer an opinion on that, this morning, Mr. Chairman.

I do want you to be aware that a rigid set of national standards, in my view, could stifle the evolving regulatory structure responding to new products and new abuses. It could stifle new product development, and we have seen great creativity and some useful advances in the product line, in recent years.

Finally, the recent experience in the medigap regulation is of some concern when we talk about Federal standards. We, in the State regulatory community have received quite inconsistent directions. We have worked with our members to adjust our regulatory formats accordingly, and in OBRA 1990, are now subject to a level of Federal oversight that we do find unacceptable.

So in the event that we talk national standards, I encourage you to keep responsibility for development of standards with the NAIC and State insurance regulators, keep the drafting pen in the hands of the regulatory technicians that have worked with this product from the beginning and brought our regulations to the point they are today.

Thank you, Mr. Chairman.

[The prepared statement follows:]

TESTIMONY OF EARL POMEROY
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

I. Introduction

Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to discuss the important topic of long-term care insurance.

My name is Earl Pomeroy and I am the elected Commissioner of Insurance in the State of North Dakota. I am testifying today on behalf of the National Association of Insurance Commissioners ("NAIC"), which is a nonprofit association whose members are the insurance officials of each state, the District of Columbia, and four U.S. Territories. The purpose of this testimony is to briefly discuss the regulatory challenges presented by the growth of the long-term care insurance market and to outline the measures that regulators, through the NAIC, have taken to meet those challenges.

II. The Long-Term Care Insurance Market

Long-term care insurance is a growing market primarily focused on sales to older consumers. Well over 1 million policies have been sold and at least 100 carriers have offered policies in the past few years. In addition, employers are beginning to show interest in sponsoring long-term care insurance plans for their employees and their families, although to date a very limited number of such policies have been sold. Most recently, insurers have been exploring different types of insurance products, including long-term care disability products and advance payments of life insurance benefits for long-term care.

Over the last two to three years, policies have improved in response to strengthened regulatory standards and increased consumer knowledge. Policies now offer broader and more flexible benefits with less severe restrictions and limitations. For example, policies offered today usually provide coverage for longer periods in a wider variety of settings than those offered just a few years ago. Prior hospitalization and prior nursing home-stay requirements also have been eliminated as benefit triggers in most instances.

Despite these improvements, however, policies still have important limitations which cause consumers to face uncertainties about product performance. Indemnity benefits, with limited periods of coverage, may not meet the cost or duration of service needs of the policyholder. Further, while options for increasing benefits over time are usually available, the options offered by many insurers fail to keep pace with increases in the costs of services. The NAIC recently amended its Model Standards to mandate that insurers offer compounded inflation protection (at 5 percent) to consumers, although insurers may offer additional methods of benefit increases that offer less protection.

Another uncertainty for consumers is that insurers may seek to raise premium rates if adverse experience develops over time. Because of the many unknowns associated with these products, such as limited data about utilization of long-term care services, limited actual claim experience from an insured environment, and the changing nature of the long-term care delivery system, the utilization assumptions and premium calculations made by insurers are less certain than with more traditional health insurance products. Insurance departments must rigorously review rate requests to assure that increases are warranted and appropriate.

Generally, these product limitations reflect the uncertainties

facing insurers trying to design and price coverage for long-term care. Long-term care insurance requires insurers to predict events far into the future, often twenty or thirty years or more. Such predictions are difficult for many reasons. The data upon which insurers are estimating the future incidence and duration of nursing home use is not complete and may not reflect how use of long-term care services may change when individuals have insurance. Future utilization patterns of home health care and other community services are even less predictable. The future availability and cost of long-term care services also are difficult to predict, in part because both supply and price will be significantly influenced by the actions of state and federal governments. New long-term care services, such as adult day care, also are being developed. Insurers and regulators must evaluate how these and other changes in the long-term-care service environment may affect the use and costs of services far into the future.

III. Development of Model Standards

NAIC Model Standards

State regulators have reacted to this evolving market by promulgating minimum standards for long-term care insurance products. The NAIC Long-Term Care Insurance Model Act was originally adopted in December, 1986, and a Model Regulation was adopted in December, 1987. Both the Model Act and Regulation ("Model Standards") have been amended to reflect greater regulatory scrutiny and changes in the marketplace.

In developing Model Standards for these products, the NAIC has attempted to balance the need for strong consumer protection with the need for innovation and flexibility in product development. The Model Act's stated purpose is

> . . . to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance...from unfair or deceptive enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage. Long-Term Care Insurance Model Act, Model Laws, Regulations and Guidelines, Vol. I, No. 132.

The NAIC Model Standards afford a number of protections to consumers. These provisions, and the Model Standards in general, reflect input which the NAIC and the states solicited from regulators, consumer organizations, and members of the insurance industry:

- Preexisting condition exclusion periods of longer than six months are prohibited.
- Purchasers have a 30-day free look period during which they may return the policy for a full refund.
- Policies may not exclude coverage for Alzheimer's disease.
- Policies may not limit coverage to skilled nursing care nor provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- Prior hospitalization requirements are prohibited.
- Conditioning eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care ("step-down") is prohibited.

- Significant minimum provisions for home health care benefits are prescribed, including prohibitions against tying benefits for home care to the need for skilled nursing, covering only services by registered or licensed practical nurses, or limiting coverage to services provided by Medicare-certified agencies or providers.

- Individual policies must be guaranteed renewable and group products must provide for continuation or conversion of coverage.

- Purchasers must be offered the opportunity to purchase a product with inflation protection with compounded annual benefit increases of at least 5 percent.

- Protections against post claims underwriting are prescribed, including a requirement that insurers keep records of policy rescissions and report them to insurance commissioners.

- Individual policies must meet a 60% loss ratio.

- Insurers must establish auditable standards for marketing, including:

  -- fair and accurate comparisons of policies;
  -- assurance that excessive insurance will not be sold;
  -- notification to applicants of limitations of coverage;
  -- identification of existing coverage; and
  -- notification of the availability of a senior counseling program if one exists in the state.

- Twisting, high pressure sales tactics and cold-lead advertising are prohibited.

- Agents must determine the appropriateness of a recommended purchase prior to sale.

- A detailed outline of coverage must be delivered to all prospective applicants for long-term care insurance at the time of initial solicitation.

- Delivery of a buyers guide is required prior to sale. The NAIC adopted a long-term care buyers guide for use by the states in 1990.

- An optional limitation on agent compensation is included which prohibits payment of first year commissions which are substantially greater than renewal commissions.

In addition, the NAIC has added a separate long-term care insurance experience reporting form to the annual statement filed by all multi-state insurers. The form will gather information on a policy form basis about premiums, claims, reserves, and number of insured individuals on both a cumulative and durational basis. These reports will permit regulators in each state to compare a policy's expected and actual experience as it unfolds and will allow earlier intervention if pricing assumptions (including lapse assumptions) are inaccurate.

Current Activities

The NAIC continues to closely monitor the long-term care insurance marketplace so that state regulators can identify and respond to problems and new developments. Currently, an NAIC task force is working in several important areas, including developing Model Standards for nonforfeiture benefits. During 1990, the task

force, assisted by an actuarial advisory committee, began to review the benefit and price effects of including nonforfeiture values in long-term care insurance policies. In December, the task force preliminarily determined that a nonforfeiture benefit should be offered to all purchasers. In March, 1991, the task force held a hearing in Washington D.C. to solicit additional input from experts on this issue. The goal of the task force is to develop one or more Model nonforfeiture benefits to be adopted by the NAIC in 1991.

The task force also will be working to produce technical assistance materials to assist departments in reviewing long-term care policy forms and rates. Because these are new and evolving products, state regulators have had no clear benchmarks by which to assess policies or premiums. Through the task force, we believe that we can pool the collective experience and knowledge of interested state regulators to develop guidelines, protocols and questions which can focus policy and rate reviewers on areas of potential problems or concerns.

Another issue for the task force in 1991 will be developing rules to assure that existing policyholders have an opportunity to "upgrade" their coverage if their insurer improves the policies it offers to the public.

IV. Assuring Consumer Protection

State Adoption of Standards

Few states had specific standards for long-term care insurance just five years ago. Presently, forty-eight states have adopted legislation or regulations for long-term care insurance, with the majority based on the NAIC Model Standards.[1] These state laws and regulations vary to some degree from the current Model Standards due to periodic amendments by the NAIC as well as differences in decisions made by various state policymakers and regulators. States have largely adopted those provisions that have been in the NAIC Model for several years, such as the prohibition against prior hospitalization. Newer provisions, such as the requirement to offer inflation protection, have been less widely adopted at this point, although we expect continued state interest in modifying and improving their regulatory standards for these products.

In the states, as in Congress, the issue of standards for long-term care insurance must compete for attention with many other important health care issues, such as access to health care, medical malpractice, and AIDs. Further, in the last two years, state legislators and regulators have had to react to changes in the Medicare supplemental insurance market caused by the passage and repeal of the Catastrophic Coverage Act. All fifty states (and the District of Columbia) have needed to twice make extensive changes to their laws and regulations for Medigap insurance since the Catastrophic Coverage Act was passed in 1989. And of course, states will need to make significant further changes as a result of OBRA-90.

The NAIC will continue to urge its members to push for adoption of the most recent Model Standards for long-term care insurance products in their states. We continue to believe that the states can and will develop and implement appropriate regulatory standards for these evolving products.

Need for Public Policy

Designing appropriate standards for long-term care insurance products is made more difficult by the absence of an articulated

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[1] Legislation or regulations are pending in the other two states.

public policy about how society should meet the long-term care needs of its citizens. The long-term care insurance market began with much fanfare about five or six years ago. Medicaid, a welfare program, was and is the only public response to long-term care needs, and public policymakers and consumers alike viewed long-term care insurance as an alternative to impoverishment and a potential new financing source. Many also saw expansion of private coverage as producing potential savings for Medicaid.

More recently, policymakers, academics and advocates have focused on the limitations of these products. Many would argue that all policies should provide more comprehensive coverage, including longer periods of coverage, home care benefits, inflation protection, and nonforfeiture values. They believe that more comprehensive coverage, available to a more limited number of consumers, is the appropriate direction for this marketplace.

In developing Model Standards, the NAIC has seen its role as balancing the needs of consumer protection and market development. As standards were developed, consideration has been given both to consumer needs as well as the potential effects on availability of products and their affordability to consumers. Since consumers have no real alternatives (except impoverishment), we have been concerned about pricing the product beyond the reach of moderate-income consumers. As this market matures, however, policymakers (including regulators) must to make decisions about whether minimum standards should emphasize affordability or should push insurers to develop much more comprehensive, but less affordable, products.

V. Conclusion

The appropriate role of long-term care insurance in meeting the financial needs of consumers must continue to be a topic for discussion and debate at both the state and federal levels. For its part, the NAIC will continue to closely monitor this market and move to address new issues or problems as they arise.

Thank you for inviting me to present the NAIC's regulatory approach to long-term care insurance. I would be happy to answer any questions at this time.

Chairman STARK. Thank you.

Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

Welcome back, Mr. Pomeroy, glad to see you again.

Mr. POMEROY. Thank you.

Mr. GRADISON. How many professionals do you have working in your State insurance department?

Mr. POMEROY. There are 35 of us, Congressman, in the insurance department.

Mr. GRADISON. And what are their responsibilities; what product areas do you get into? Accident and health, health insurance short-term and long-term, group?

Mr. POMEROY. Yes.

Mr. GRADISON. Individual?

Mr. POMEROY. All of it.

Mr. GRADISON. How about property and casualty insurance?

Mr. POMEROY. Yes.

Mr. GRADISON. Life insurance?

Mr. POMEROY. That too.

Mr. GRADISON. Annuities?

Mr. POMEROY. Yes.

Mr. GRADISON. Well, you know, I think you got more people than the State of Ohio has in its insurance departments. I don't mean that as an invidious comparison. I think there is an assumption here that there is just a huge reservoir of skilled regulators out there that can instantaneously take these brilliant national ideas we have and apply them to their States. I think you are doing a tremendous job with the resources that you have.

When I look at the body of health law—and I am not just talking about insurance law, but health law—that we passed around here in the last few years, I think one of the nicest things that we could do for the system would be, not to adjourn, but to focus on oversight rather than passing a lot of new laws, just for a couple of years to let people catch up with the changes that we have made.

Thanks a lot for coming.

Mr. POMEROY. Thank you, Congressman.

Chairman STARK. I want to associate myself with your remarks because I think what we are talking about is trying to pass the laws that they have already written. I mean, not us, but that the insurance commissioners are asking for.

I looked at your model law. Just sign me up. A couple of questions on that. You have a 60 percent loss ratio?

Mr. POMEROY. Yes.

Chairman STARK. And that is a variable, but then you are also looking at the nonforfeitures.

Mr. POMEROY. Yes, sir.

Chairman STARK. Does that tie together, mathematically? Is it generally true that the lower the loss ratio, the higher the reserves?

Mr. POMEROY. Mr. Chairman, we're not going to talk about loss ratios very far, before we go beyond my actuarial expertise.

Chairman STARK. OK.

Mr. POMEROY. But I will tell you that we believe as a matter of fundamental fairness, the policy needs to return a reasonable

amount of premium back in claims payment. That is an indication of the legitimacy of the product.

Therefore, we have put in a loss ratio measurement and we now require a fairly elaborate reporting of companies in their annual financial statement so that we can closely track their actual experience in the long-term care book that they are writing.

Chairman STARK. Now, in your nonforfeiture benefit, that I understand you are working on at NAIC, do you know whether it is likely to be mandatory or voluntary?

Mr. POMEROY. Mr. Chairman, the two options before us will be every policy must include a nonforfeiture benefit, or a mandated offer alternative, wherein, any policy sold the consumer must be offered the choice.

That debate is raging, as we meet. There is a value to nonforfeiture, but the price impact raises the countervailing issue.

Chairman STARK. There's no way to compromise? I mean there is no term policy that would—OK.

I understand that.

Mr. POMEROY. Mr. Chairman, I think that the regulators instinctively like to allow the market as much choice as the market can reasonably handle without undue abuse occurring.

I believe that sometimes there are those, in Congress, that believe the market needs more protection restricting consumer choices than the regulatory community believes. I think there is plenty of good reason for either view—the mandated option or the mandated nonforfeiture benefit—on the nonforfeiture issue.

Chairman STARK. I have to correct myself. I would sign up for your model if you added a required compounded inflation protection. I did not read it carefully enough.

I presume you are going to add some nonforfeiture values, but I cannot figure out how to do it. I will have to wait for you to do it anyway.

I want to give you a lesson in politics. I can understand why he is no longer president of the NAIC because these policies that you have outlined are very much like the 1989 model. Were they not, in your testimony, the ones that you talk about twisting the auditable standards for marketing, the 60 percent?

Mr. POMEROY. No, Mr. Chairman.

Many of these have recently been incorporated, as recently, actually as December 1990.

Chairman STARK. OK. It was just 2 years ago that a brilliant strategist, an expert in the industry, told this committee that in the event that in 2 years we are still looking at major chunks of the country that have failed to enact meaningful protections, I believe we, meaning NAIC, will not have much resistance.

Then, during a hearing at the Committee on Energy and Commerce, in May of last year, it was said the model is not adopted as widely as I would like it to be as we meet today. And testifying a year ago to the Health Subcommittee of House Ways and Means, I indicated that if within a period of 2 years from that hearing the States didn't demonstrate comprehensive adoption of that legislation of protections of at least that level, the NAIC would no longer oppose a national imposition of minimum standards.

There is no wonder that they got a new president. A guy who is going to sign up with this committee so early. Now I have to get the new president to come in here and testify to that, don't I?

Mr. GRADISON. Mr. Chairman, I——

Chairman STARK. Mr. Gradison.

Mr. GRADISON [continuing]. I am inclined to cry foul. I mean somebody might try and do that to one of us some day.

Chairman STARK. I say we had to have some——

Mr. GRADISON. But I think the witness should be complimented for his willingness to examine new facts and reexamine previously held positions. [Laughter.]

Mr. GRADISON. There are many people who have said that I am unable to do that. So I respect his ability to do so.

Mr. POMEROY. Well, Mr. Chairman, and Congressman Gradison, the position of the NAIC is that—the pledge that I made was that the States would continue to work on the regulatory framework for long-term care insurance. We have. We have improved the model significantly since the hearing 2 years ago.

Second, the pledge was that in reasonably comprehensive fashion, States would enact the NAIC model provisions. Now, if we look back toward the provisions of the model in effect, as of the date of that hearing 2 years ago, the States have quite a good track record in terms of bringing themselves into compliance. And they lag a little bit, relative to some of the newer aspects of the model.

I believe that comprehensive is in the eye of the beholder. I think the States have made a reasonably comprehensive attempt. You have not heard in my testimony, however, a flat out fall-on-the-sword opposition to Federal minimum standards in accordance with the representation made 2 years ago.

Chairman STARK. As I said, if we could do anything to help you in getting more States. There are still, and I don't know if these are all the same States that I mentioned earlier—there are 24 States who presumably do not have guaranteed renewal which was an 1988 standard. There are 17 States who still do not have the prohibition on Alzheimer's. There are 12 States who do not prohibit coverage based on prior hospitalization and 11 States who do not prohibit policies from limiting coverage to skilled care.

I would say 24 States are not comprehensive and 11 gets close to being there. I just have a hunch that as the insurance world gets more complex and people become more mobile that we are going to be involved at the Federal level, whether it is this subcommittee or someone else.

I would both thank you for your willingness to cooperate with us, and hope that we can work together and let's say it is out of our hands. The genie is out of the bottle. There's going to be some overlap between Federal and State regulation. And Mr. Gradison has indicated, that can be a problem.

But we can also be part of the solution. Let's say we didn't start the problem necessarily. You didn't, and I am sure that this committee didn't enterprise this idea. But if it is going to happen, maybe we could do something to make it work better.

I would invite you once again, to work with us especially in the area of nonforfeiture. Unlike life insurance, long-term care insurance does not have a tradition and a sophistication of its actuarial

predictions that are so precise that it is a lot easier to figure out what that ought to be.

I would not have the foggiest idea what you could do or what would be fair to consumers. And maybe that it something left off the table. But I would hope that there is a way out of it.

I would suspect that your industry is going to fight and not want to make it mandatory, but mandatory options might be OK. We need help.

Mr. POMEROY. Mr. Chairman, we are leaning toward mandatory options. Back, just on the comprehensive aspect of it, again, I believe that States have acted where they have had a problem. Prior hospitalization was a problem.

Companies were routinely having that aspect, that feature in their policies, and we have got about 40 States, again, approaching comprehensive, that have now prohibited prior hospitalization. We are seeing it come out of policy forms.

How in the world can you have half the States not address Alzheimer's, the most obvious consumer protection issue raised in long-term care insurance? I believe it is because they have not had problems with it. Companies have not put Alzheimer's exclusions in their policies. I strongly believe States ought to, by regulation, prohibit it and they ought to have it on the books and they ought to be ashamed of themselves if they don't have it on the books. But in reality, those States that don't have it on the books, are not having consumers with benefits denied because of policies written with an Alzheimer's exclusions. It is not in the policies being marketed.

Chairman STARK. I guess one measure, and I should read the policy more carefully, but the measure would be how many States can American Integrity sell policies in? In North Dakota?

Mr. POMEROY. Mr. Chairman, we maintain a hall of shame of companies that have given us some difficulty. That is not one at the very top of the list in the experience of our State.

Chairman STARK. But then in that hall of shame, how many States can those award winners operate in? It is not the blue ribbon companies, big and small. Maybe you have a rural cooperative or a farmer's mutual or something that is indigenous to North Dakota. I have no quarrel with that.

There are, indeed. Even in politics there are some bad apples in the barrel.

Mr. POMEROY. So I have heard.

Chairman STARK. And not all of us get to feed it. But the point is that that is really the measure. To allow somebody to deal with the more fragile citizens, seniors, people who are more easily confused. I am living testimony that the older you get, the easier it is to confuse you. We ought to protect them from the operators.

Now, when we get down to having to draw the regulations, those guys out of business or make it very difficult for them to ply their trade?

Mr. POMEROY. Mr. Chairman, the insurance regulatory community, I believe, more than some other State licensure, or regulatory bodies, have a very advanced level of communication with one another. Aside from daily online access to a computer which on an ongoing basis tracks disciplinary activity taken against companies,

we meet quarterly, we have committee meetings, even more often than that and word gets around.

A company that caused a great deal of trouble through horrible, reprehensible market conduct was Provider's Fidelity out of Pennsylvania. They became a clearly identified bad actor and I believe States watched very closely their activity and in conjunction had a level of regulatory scrutiny that ultimately curtailed the abuses of that company.

I cite that as a real, living example of how this information is shared and regulatory responses are coordinated.

Chairman STARK. I have no quarrel. As I say, I think I would like to make it clear that it is not the Blue Crosses and the Aetnas who are testifying today who should be tarred with these concerns. While they may not all have every benefit, or every standard clause in the policy that you or I might like to see, I think they are all acting in good faith to provide a valuable service and a product.

It is, in fact, the bad actors that your organization and this committee are concerned about. To the end that we can make life miserable for them we will ask for your help and see if together we can't make it even more miserable than we can individually.

Mr. POMEROY. Making life miserable for that group is our stock and trade, we would be happy to.

Chairman STARK. And with that, the hearing is adjourned.

Thank you, very much, Mr. Pomeroy.

Mr. POMEROY. Thank you, Mr. Chairman.

[Whereupon, at 12:01 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

ROLAND W. BURRIS
ATTORNEY GENERAL
STATE OF ILLINOIS

April 19, 1991

The Honorable Pete Stark
Chairman
House Subcommittee on Health
Committee on Ways and Means
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to submit this letter to your Subcommittee on Health and I respectfully request that it be entered into the record of the hearing on private long-term care insurance and standards for improved consumer protection.

This letter is intended as a means of alerting your Subcommittee to substantive concerns which, from a consumer perspective, would be appropriate to address through federal legislation.

National experience with the sale of Medigap insurance proved that Congress was right when it passed legislation prohibiting abuses by agents and insurance companies. Agents often duped unsuspecting consumers into buying duplicative or worthless policies. Administrative and marketing costs, along with profits, often consumed as much as 50-70 percent of the premium revenue.

Congress confronted these problems by amending the Social Security Act (Act) in 1980. The Baucus Amendment to the Act established minimum standards with respect to benefits, simplicity of policy language, agent abuses, company abuses, and many more provisions. Public confidence in the purchase of Medigap insurance is now at a very high level because Congress took the "bull by the horns" and regulated Medigap insurance. Now, Congress should once again provide leadership by mandating minimum standards and safeguards in the sale of long-term care insurance.

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Listed below are issues that I suggest be addressed by your Subcommittee during this Congressional hearing:

(1) **Long-term care policies should pay benefits for all levels of care, not just skilled care or intermediate care.** Every policy pays benefits if the insured needs skilled care; however, many policies exclude benefits for custodial care. Custodial care is the most frequently utilized level of care. Therefore, consumers are at a great disadvantage if a policy excludes custodial care. Also, custodial care should be defined to include dysfunctioning of activities of daily living (ADL's). In other words, the policy should pay benefits for custodial care if the insured needs assistance in walking, feeding, bathing, getting in and out of bed, or toileting. The number of required ADL's should be capped at either 2 out of 5 or 3 out of 5.

(2) **Insurance companies should be required, at the option of the insured, to offer home health benefits.** Some long-term care policies provide home health benefits as an alternative to institutionalization. Consumers should have the option to purchase home health benefits. Institutionalization should be the last resort and not the only option available. Home health benefits help consumers maintain an independent life style and reduce the reliance on costly nursing home care.

(3) **Insurance companies should be required to offer, at the option of the insured, inflation protection benefits.** Long-term care policies pay a fixed amount per day (an indemnity) even if the cost of nursing home care increases. Some companies offer an inflation protection benefit which adjusts the daily benefit paid to offset the effects of inflation. Normally, benefits automatically increase by 5 to 10 percent each year for 10 to 15 years, for example. Inflation protection is an excellent way to protect consumers from the effects of inflation.

(4) **Prohibit prior hospitalization requirements.** Many policies require a period of hospitalization (usually three days) prior to entering a nursing home. This is commonly called a "gatekeeping" provision intended to assure medical necessity. This provision greatly limits access to coverage for persons suffering chronic diseases or conditions such as Parkinson's or Alzheimer's diseases. These diseases may not necessitate hospitalization but may ultimately require nursing home care or the services of a home health agency.

(5) **Prohibit provisions linked to level of care.** Some policies base eligibility for lower levels of care solely on the receipt of higher levels of care -- (usually skilled care). Very often a person enters a

nursing home and receives custodial care for several years before, if ever, he needs the skilled care level. This provision unfairly favors insurance companies by allowing them to deny benefits based upon an arbitrary standard.

(6) **Establish a reasonable waiting period.** Most policies exclude coverage for pre-existing conditions for periods ranging from 90 days to two years, with six months being the most common. The National Association of Insurance Commissioners recommends a six month waiting period and we agree.

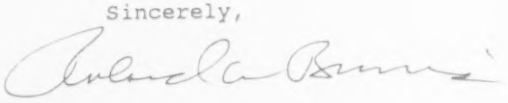
(7) **Establish a 30-day free-look period.** A consumer should have the right to return a policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the consumer is not satisfied for any reason.

(8) **Agents should be required to provide the consumer with an Outline of Coverage.** An Outline of Coverage is separate from the policy itself. It should be printed in a readable type-size (no smaller than ten-point type) and provide a brief description of the important features of the policy.

(9) **Require that long-term care policies be guaranteed renewable.** A policy with conditional renewability allows insurance companies to cancel a policy at any time. Every long-term care policy should be guaranteed renewable. This means they cannot be canceled by the company as long as the policyholder pays the premiums on time.

Thank you for the opportunity to present my views to you. The Office of the Illinois Attorney General stands ready to work with the Subcommittee on Health in a mutual effort to provide adequate protection to consumers in the purchase of long-term care insurance.

Sincerely,



Roland W. Burris

STATEMENT OF MARTHA McSTEEN, PRESIDENT NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. The average age of our nearly five million members is 69, an age at which many people begin to worry about protection from financial devastation should long-term care be required. The need for a public long-term care program is imperative. However, until such a system is in place, seniors are left with few choices--they can "spend down" to a level where medicaid pays for long-term care or, for those who can afford it, purchase private long-term care insurance.

The National Committee applauds you, Mr. Chairman, and your colleagues for your efforts to reform first the medigap insurance market and now the long-term care insurance market. The National Committee strongly supported federal standards for medigap. Last year, our members sent close to 200,000 postcards and letters to Congress asking for medigap reform. This year, the National Committee is prepared to work equally hard for federal standards that can protect seniors from the fraud and abuse repeated in the long-term care market.

Now is the opportune time to implement federal standards, particularly considering the increasing importance of private insurance. The long-term care insurance market has grown rapidly over the last few years to more than 1.7 million policies as of June 1990, according to the Health Insurance Association of America. The number of people willing and able to purchase long-term care policies, while still relatively small, is likely to increase as the baby boom generation matures. Without reforms, many of those who are trying to provide for themselves will end up with a false sense of security. While many of the improvements have a cost and may increase premiums amounts, the protection is more genuine.

The following are some of the reforms that the National Committee would support in legislation.

Pre-existing conditions and renewability. Waiting periods before benefits can be paid due to pre-existing conditions such as stroke or heart disease should be limited and clearly explained to consumers. Likewise, new waiting periods should not be permitted when switching policies. Most current generation long-term care policies are guaranteed renewable. However, only nonpayment of premiums should be just cause for the cancellation of an individual policy under new federal guidelines. Seniors must be assured that their policy can be renewed no matter what their age or their health condition.

Prior hospitalization. New long-term care insurance policies have clearly improved compared to earlier products which required prior hospitalization and exclusions for diseases such as Alzheimer's. However, the National Committee is concerned about seniors continuing to pay premiums on these early policies only to find there is no coverage when the time comes. Notification by insurance companies to policyholders of these early, less generous policies should be required. This provides the opportunity for individuals to purchase updated, less restrictive policies if desired.

Skilled level of care and other restrictions. Some current generation policies require prior skilled nursing home stays before covering home care. Many chronic diseases such as Parkinson's, Alzheimer's disease and other organic brain syndrome diseases do not include acute episodes requiring skilled levels of care. Long-term care policies should not require a higher level of care before paying benefits. Also, policies should not single out certain diseases that it will not cover, such as mental illness, forms of senile dementia, or any other type of chronic illness.

Home Care. Staying home is the favored choice of most seniors when needing long-term care. A 1990 United Seniors Health Cooperative study found that "most long-term care insurance policies do not provide adequate enough coverage of home care to play a meaningful role in financing home care" for seniors. Insurance policies should offer coverage for home and community-based care allowing seniors more choice.

Inflation protection. Current generation long-term care policies on the market today include the option to purchase an inflation protection rider. The National Committee believes it is essential to incorporate in all policies this inflation protection as a standard benefit. A nursing home bed that today costs anywhere from $45 to $200 a day may double in price in a few years. It is important that consumers of long-term care policies be informed about this potentiality and about the importance of having inflation protection. Consumers should also have the option to upgrade the policy at scheduled intervals without a waiting period. The offering of a five percent inflation adjuster as has been discussed may not be sufficient in the light of double digit health care costs.

Nonforfeiture values. For a 65-year old person, a typical long-term care insurance policy costs about $100 a month. After paying thousands of dollars in premiums over the next twenty or more years, an individual may, for whatever reason, no longer be able to keep up payments at a time in life when the possibility of needing long-term care is greatest. Some guaranteed protection of their investment should be awarded such individuals. Policies with built-in equity in the form of cash values or extended insurance coverage should be seriously considered.

Counseling. Many people, young or old, are confused by insurance language and need unbiased advice by experts before purchasing an insurance policy. It is especially important that seniors who often are targets of the latest sales techniques have a place to turn for advice. The grants to states for insurance counseling included in last year's medigap reform law should be increased.

Prior authorization of rate increases. To protect seniors from unnecessarily high premium increases on their long-term care policies, the National Committee urges that insurance companies be required to obtain state approval before implementing rate increases. State insurance offices should have the capacity to calculate the actuarial value of policies and determine if proposed premium rate increases are justified. Consumers should be part of the process through public hearings held by the state insurance regulatory agency.

Simplification of language. Policy language should be clear and simple with standardized terms to ease understanding and comparability between policies.

To illustrate the need for reform, the following three case studies of problems experienced by National Committee members are submitted for your consideration.

Case Example One.

Mr. and Mrs. S. in Campbell, Minnesota, were 80 and 78, respectively, when they bought their long-term care policy. After reading an ad in the paper they went to talk to the insurance agent. The policy they chose would cover $60 per day for nursing home care. Everything was made easy. No physical exam was required. All they had to do was fill out a short health questionnaire. Mrs. S., in good faith, explained on the questionnaire that Mr. S. had undergone open heart surgery the year before and recovered fully, and that there were no other pre-existing conditions. They paid $1,600 to cover a full year's premium. Mr. and Mrs. S. were under the distinct impression that

there was no waiting period--backed up by the insurance agent's recounting of a case where benefits were paid out after only two months.

As it happened, Mr. S. was hospitalized with a stroke three months after the purchase of the policy. During the hospitalization, he was diagnosed with organic brain disorder. Nine month after the purchase, Mr. S. entered a $45 a day nursing facility. The insurance company refused to cover the stay as this was interpreted as a pre-existing condition and returned the $1,600 check to Mrs. S. In the meantime, she spent $27,000 last year for his nursing home care plus $2,000 for medication, and currently faces the choice of relying on Medicaid or taking him home. She is now 80 years old and not in good health. She is upset and feels "cheated by the insurance company."

The National Committee has not seen this member's policy and does not know if the insurance company is legally responsible or not. What we do know is that the terms under which policies are bought must be made absolutely clear so that seniors are not left with a false sense of security.

Case Example Two.

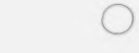
Mr. and Mrs. C. of Pompano Beach, Florida, purchased a long-term care policy several years ago before Mr. C was diagnosed with Alzheimer's Disease. Mrs. C. has been her husband's caregiver since 1989 and is becoming increasingly exhausted and does not think she can sustain this care much longer. Both are 82 years old. She must place him a nursing home in order to preserve her own health. But to her horror, she discovered that the long-term care policy for which she pays $1,500 annually, will not cover her husband's nursing home stay. It requires a prior stay in the hospital before paying out benefits.

Most people are under the impression that a requirement for prior hospitalization is no longer an issue, forgetting that there are many old policies already sold that still include this requirement.

Case Example Three.

Mr. N. of Chapel Hill, North Carolina, is 73 and suffers from severe angina. He lives alone and has no family to care for him. He is deeply concerned about what is going to happen to him--he is in and out of the hospital and believes that for him chances of going to a nursing home are high. He carries a nursing home policy for which he pays $185 per month, a premium he can barely afford. This is his second policy. According to Mr. N. his first long-term care policy was sold to him by a "sales agent who was crooked and ended up in jail."

One of Mr. N.'s greatest frustrations with his current long-term care policy is that he is still not completely clear as to what it covers and under what circumstances it will apply. "You need a law degree to understand these policies. They hide behind little, hard-to-read clauses," he states. Mr. N. recommends that the language be made very clear and that services be set up where seniors can receive non-biased advice on the selection of a policy.

In conclusion, the National Committee believes that federal standards are necessary to assure protection for consumers through better quality long-term care private insurance policies. We stand ready to work with you and members of the Subcommittee in ensuring that consumers receive the information they need to make appropriate long-term care insurance decisions.

Thank you, Mr. Chairman, for the opportunity to express the views of the National Committee.